EXHIBIT “A”

KINGSBROOK
JEWISH MEDICAL CENTER

RUTLAND NURSING HOME

April 3, 2019

Good day.

To whom it may concern,

Please be aware that Mr. Jean Francisque has been admitted to Kingsbrook Jewish Medical Center/Rutland Nursing Home since 3/6/2019 and continues to reside here. There is no plan for discharge at this time.

Due to his medical condition, Mr. Francisque is unable to make any medical and financial decisions at this time. All his needs are anticipated by his wife, Gladys Francisque, and the medical staff at the facility.

Should you need further information do not hesitate to contact us at the telephone # provided below.

Thank you.
Sincerely,

Berhane Wubshet MD
Tele# 1-718-604-5000

BERHANE WUBSHET, MD, MPH

Rutland Nursing Home
585 Schenectady Avenue • Brooklyn, NY 11203-1809 • Tel. 718-604-5000

Current Date: 03/07/2019

03/06/2019

ADMISSION FACE SHEET

TW-1013B

Jean Francisque

MRN / ID	New Admit	DOB	Sex	Race	Religion
370519	Yes	[redacted]	Male	BLACK	CATHOLIC

Previous Address		Home Phone	Cell Phone
25 TENNIS CT 2E	Brooklyn, NY 11226	(917)325-1931	

Admission Date	Transferring Facility	Hospital of Qualifying Stay From/To Dates		Marital Status
03/06/2019	KINGS COUNTY HOSP	02/07/2019	03/06/2019	MARRIED

Primary Admitting Diagnosis	Secondary Admitting Diagnosis
I61.9 Nontraumatic intracerebral hemorrhage, unspecif	I10 Essential (primary) hypertension
Z43.1 Encounter for attention to gastrostomy	E11.00 Type 2 diabetes mellitus with hyperosmolarity

Social Security Number	Billing Account #	Medicare Number	Medicaid Number	Primary Payor
[redacted]	1643155	101541756A		AETNA MCR

Insurance Provider	Member ID #	Authorization #	Auth # End Date
AETNA	W247255639A	57990740-1000	03/10/2019
Supplemental Insurance	**Member ID #**	**Part D Plan**	**Part D Policy #**

Case Manager	Phone #	Fax #
ALYSSA	860-687-5608	959-282-1043

Primary Physician	Address	Phone #
BERHANE WUBSHET	9408 FLATLANDS AVE BROOKLYN,NY 11236	(718) 272-0977
Secondary Physician	**Address**	**Phone #**
AKBARALI G VIRANI	1834 ROCKAWAY PRKW BROOKLYN,NY 11236	(646) 739-0343

Hospital Physician	Address	Phone #
BERHANE WUBSHET	9408 FLATLANDS AVE BROOKLYN,NY 11236	(718) 272-0977

Next of Kin 1	Relation	Address	
FRANCISQUE, GLADYS	SPOUSE	3811 AVE I	Brooklyn, NY 11210
Home Phone	**Work Phone**	**Cell/Pager**	
917-325-1931			
Next of Kin 2	**Relation**	**Address**	
FRANCISQUE, KATIE	DAUGHTER	3211 AVENUE I 2M	Brooklyn, NY 11210
Home Phone	**Work Phone**	**Cell/Pager**	
718-753-9490			
Emergency Contact	**Relation**	**Address**	
Home Phone	**Work Phone**	**Cell/Pager**	

Funeral Home Information	Phone #

DISCHARGE / READMISSION HISTORY

Original Admit Date 03/06/2019

Transfer Date	Transfer To	Return Date	Returning Diagnosis

ADMISSIONS & DISCHARGE RECORD

KINGSBROOK JEWISH MEDICAL CENTER

Name

Number

Loc/Sex/Age

Doctor

ADMISSION NO.	UNIT CHART NO.	DATE ADMITTED	TIME AM PM
	370519	03/6/19	
PREV. ADMISS. DATES	STAY IN HOSPITAL	DATE DISCHARGED	

NAME: Francisque, Jean — REFERRED BY: Wbshet

FOR PATIENT PLATE

ADDRESS — CITY: RNH — STATE — ZIP — TELEPHONE NO.: 7305 — ADMITTED TO DEPT.: TW-013B — UNIT

OCCUPATION

AGE	SEX	MARITAL STATUS (M S W D)	SOCIAL SECURITY NO
71	M	M	XXX-XX-[redacted]6

BIRTHPLACE — RELIGION: Catholic

TRANSFERRED TO: (TO BE COMPLETED BY NURSING UNIT MAKING TRANSFER)

DEPT.	DOCTOR	UNIT	DATE

DIAGNOSIS ON ADMISSION. (To be filled out by admitting Physician) — CODE (MED. REC)

DIAGNOSIS ON DISCHARGE (To be filled out by Physician discharging Patient)

COMPLICATIONS

OPERATIONS — DATE

OPERATIONS — DATE

SPECIAL THERAPY

CONDITIONS ON DISCHARGE — SIGNATURE

Recovered ☐, Improved ☐, Unimproved ☐, Deceased ☐

AUTOPSY	M.E. CASE	APPROVED BY	APPROVED BY
Yes ☐ No ☐	Yes ☐ No ☐	M.D.	M.D.

RECORD COMMITTEE

CHART AUDITED BY _____ M.D. DATE _____

Form 4.1

DATE

USE

SUMMARY DICTATED BY

RUTLAND NURSING HOME
INSURANCE VERIFICATION SHEET

1. RESIDENT NAME: Jean Francisque
2. UNIT/RM#: TW-1013B
3. MR#: 370519
4. ADMISSION DATE: 3/6/19
5. NAME OF INSURANCE CO.: Aetna (MCR/HMO)
6. MEMBER ID: W247255639A
7. REASON FOR AUTH: Sub-Acute Rehab
8. AUTHORIZATION#: 57990740-1000
9. DAYS APPROVED: 5 Days
10. APPROVED PERIOD: 3/6/19 - 3/10/19
11. APPROVAL LEVEL: Level 2
12. CO-PAY: _____
13. CO-INSURANCE: _____
14. DEDUCTIBLE AMOUNT: _____
15. CONTRACTS/BENEFITS CONTACT: c/m Alyssa
    Ph- 860-687-5608 Fx- 959-282-1043
16. COMMENTS: Needs update in 48hrs.

CC: MDS Office
Bus. Office
LTCM
SW
Admin

KINGSBROOK JEWISH MEDICAL CENTER
DAVID MINKIN REHABILITATION INSTITUT
RUTLAND NURSING HOME

FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

PROBLEM NO.	DATE ENTERED	PROBLEM LIST	PROBLEM RESOLVED	DATE RESOLV
1	3/6/19	Stroke & hemorrhagic conversion PEG Placed 2/22/19		
2		HTN DM		
3				
4				
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6				
7				
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9				
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14				
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16				
17				
18				
19				

Form No. 4-1595 11/85 H.S.

RUTLAND NURSING HOME

RESIDENT IMMUNIZATION STATUS RECO

FRANCISQUE ,JEAN M 71
1256 WUBSHET, BERHANE,
VAS PT#: 11045967 DOB: [redacted]
MR#: 0370519 PH#:
REG DT: 03/13/19 TIME 09:34

Influenza Vaccine given:

_____ Date

_____ Date

_____ Date

_____ Date

_____ Date

PPD

_____ Date — INDURATIONS: Yes ( ) No ( ) MEASURMENT: _____mm

_____ Date — INDURATIONS: Yes ( ) No ( ) MEASURMENT: _____mm

_____ Date — INDURATIONS: Yes ( ) No ( ) MEASURMENT: _____mm

_____ Date — INDURATIONS: Yes ( ) No ( ) MEASURMENT: _____mm

Pneumococcal Conjugate Vaccine (PCV13)

3/19 Date Pneumonia vacc given in Hospital. See D/C Papers

_____ Date

Pneumococcal Polysaccharide Vaccine (PPSV23)

_____ Date

_____ Date

Tetanus Toxoid booster given:

_____ Date

Other Vaccine Given:

_____ Date

_____ Specify Vaccine

Other Vaccine Given:

_____ Date

_____ Specify Vaccine

BS 9/2017

Patient Summary of Care,
Agreement and Discharge Report
Patient Name: Jean Francisque
Visit #: 2840513-1

Kings County Hospital Center

Printed on: 6 Mar 19 1906
Disposition Time:

You, the patient, were provided:

* Discharge Instructions including follow-up information
* Information for your primary doctor
* Education Materials
* List of Medications
* Other _____

The following actions were performed:

[ ] Printed instructions reviewed by nurse and patient
[ ] Patient Medication List Summary from QuadraMed was reviewed by nurse and patient
[ ] Patient was checked for medical devices

Discharge instructions were provided for conditions including the following (where applicable):

[ ] Congestive Heart Failure
[X] Stroke
[ ] Warfarin
[ ] MicroMedex _____
[ ] Up To Date _____
[ ] Other Dvt, Fall

Important Notes:

Your information will also be made available to you securely in the on-line patient portal at https://myhhc.info

In addition to following up as instructed, please contact your primary doctor if your insurance assigns you one. If you are having difficulty making an appointment at Kings County, please call the Central Appointment Scheduling office during business hours at (718)245-3325.

If signs and symptoms suggest that your condition is worsening, please contact a doctor immediately. If you believe it is an emergency, please come to the ER or call 911.

_____
Patient/Parent/Surrogate Signature

I have received these instructions and had my questions answered

_____
Nurse's Signature

[ ] n/a _____
Translation Service

3/6/19
Date/Time

I have reviewed these instructions with the patient

This report contains Protected Health Information (PHI). Disclosure of this information may result in violation of your privacy.

Patient Discharge Instructions

Kings County Hospital Center

nt Name: Jean Francisque DOB: [redacted] Visit #: 2840513-1

ar Patient:

This is **your Summary of Care** for this visit. Please review it and share it with people who take part in your healthcare.

Admission Date:	7 Feb 19
Discharge Date:	6 Mar 19
Clinical Summary:	71M aphasic, subacute posterior temporal stroke, admit for workup
Immunizations	*PneumococcaL 13-Valent Conjugate Vaccine AKA -Prevnar 13
Discharge Diet	Puree/ Normal Liq.
Discharge Activities	as tolerated
Follow-up Appointments	Neurology Clinic: 3/29/19 at 2:30pm in the E building 1st floor,
Primary Care Provider:	unknown
Discharge Provider:	Hasan,Abida, MD
Attending:	Law,Susan, DO
Unit:	D2S - Medicine
Call-back #:	(718) 245 - 7156

Prescription List
No Prescriptions

Discharge Instructions

Problem: Stroke with hemorrhagic conversion
Goals and Instructions: Diagnostic clarification; Healing and rehabilitation; Patient engagement and education; Physiological improvement; Symptom control;

Problem: Reversible causes of dementia
Goals and Instructions: Diagnostic clarification;

Problem: #Code status
Goals and Instructions: Diagnostic clarification;

Problem: Persistent tachycardia

Patient Discharge Instructions

Kings County Hospital Center

Patient Name: Jean Francisque DOB: [redacted] Visit #: 2840513-1

Goals and Instructions: Healing and rehabilitation;

Problem: fever
Goals and Instructions: Healing and rehabilitation;

Problem: Loose Stools
Goals and Instructions: Physiological improvement;

Problem: Diabetes
Goals and Instructions: Physiological improvement;

Problem: Left knee pain with movement
Goals and Instructions: Symptom control;

Problem: Transaminitis
Goals and Instructions: Physiological improvement;

KCHC: STROKE DISCHARGE EDUCATION

I. STROKE RISK FACTORS

* Do you
  - have High Blood Pressure?
  - high cholesterol?
  - smoke or live with a smoker?
  - not get regular exercise?
  - eat a high fat/cholesterol diet?

* Are you overweight?

YOU CAN CHANGE THE ABOVE RISK FACTORS!

II. LIMIT YOUR RISK FACTORS

Strokes can be prevented. The key is to limit your risk factors!

HERE ARE SOME TIPS!

* Control your blood pressure.
* Dont smoke and try to avoid being around other who do.
* If you are taking any heart medicines, follow your doctors advice.
* If you drink alcohol, dont have more than 1-2 servings a day.(1 serving = 5 oz of wine or 12 oz of beer, or 1 oz of liquor).
* Eat a healthy, well-balanced diet with plenty of fruits and vegetables.
* Exercise for 30 minutes or more at least 3 times a week.
* Maintain a healthy body weight.

Patient Discharge Instructions

Kings County Hospital Center

ent Name: Jean Francisque DOB: [redacted] Visit #: 2840513-1

II. There are also stroke risk factors that you can't change

* A family history of stroke at a young age.
* Being a man over 55 years of age.
* Being a female past menopause.
* Having diabetes.

. NEED for FOLLOW-UP MEDICAL CARE after DISCHARGE

* Continue to take your medications as prescribed to reduce your risk of having another stroke
* It is important that you receive regular medical care. IF you miss your doctors appointment, call and make another appointment.

V. IF YOU ARE HAVING A STROKE - TAKE ACTION

*** KNOW THE SIGNS**

YOU MAY FEEL any of the following when having a stroke:

* Sudden weakness, numbness or tingling on one side of the body
* Drooping of your eyelid or mouth on one side of your face
* Confusion, loss of memory or sudden loss of consciousness
* Slurred speech, loss of speech or problems understanding simple statements
* Sudden severe headache for no known reason
* Trouble staying balanced, sudden falls or feeling dizzy for no reason
* Sudden changes in vision (blurring, dimming or loss of sight)
* Nausea and vomiting along with any of the above

*** ACT QUICKLY**

CALL 911 RIGHT AWAY IF YOU * A N Y * OF THE SIGNS

* Early emergency treatment can save your life and prevent or lessen brain damage
* Some treatment will not work if not done within 2-6 hours of the start of your signs of a stroke

VI. FOR SUPPORT AND MORE INFORMATION

NATIONAL STROKE ASSOCIATION
Telephone: 1-800-787-6537
Website: http://www.stroke.org

NATIONAL INSTITUTE FOR NEUROLOGICAL DISORDERS/STROKE
Telephone: 1-800-352-9424

Patient Discharge Instructions

Kings County Hospital Center

Patient Name: Jean Francisque DOB: [redacted] Visit #: 2840513-1

III. There are also stroke risk factors that you can't change

* A family history of stroke at a young age.
* Being a man over 55 years of age.
* Being a female past menopause.
* Having diabetes.

IV. **NEED for FOLLOW-UP MEDICAL CARE after DISCHARGE**

* Continue to take your medications as prescribed to reduce your risk of having another stroke
* It is important that you receive regular medical care. IF you miss your doctors appointment, call and make another appointment.

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Patient Discharge Instructions

Kings County Hospital Center

Patient Name: Jean Francisque DOB: [redacted] Visit #: 2840513-1

Website: http://
www.ninds.nih.gov/disorders/strokehttp://www.bing.com/search?q=national+institutes+of+health+stroke+information&src=IE-SearchBox&Form=IE8SRC&adlt=strict

Primary Care Provider Information **Kings County Hospital Center**

Patient Name: Jean Francisque DOB: [redacted] Visit #: 2840513-1

This is a summary of your admission **for your Primary Care Provider.** Please share it with them.

Admission Date:	7 Feb 19	Discharge Date:	6 Mar 19
Preferred Language		DOB	[redacted]
Ethnicity		Sex	M
Pt Telephone#		Race	Black or African American

Clinical Summary: 71M aphasic, subacute posterior temporal stroke, admit for workup

Hospital Course: Hospital Course:
Pt presented to the ED on 2/7/19 after being found with language deficit and not following commands. The last time known well was more than 24 hours prior. CT Head revealed subacute posterior Left MCA ischemic stroke. There was initial concern for seizure so patient was started on Keppra. However 2 EEGs showed no seizure activity and Keppra was discontinued. Initiated secondary stroke prevention with aspirin and statin. Evaluated by PT, OT, SLP who recommended SAR and PEG tube placement for dysphagia. PEG placed on 2/22/19, feeds initiated 24 hours later with no complications. Hospital course complicated by hemorrhagic transformation of stroke. Serial head CTs showed stability with no new stroke. Also, patient had uptrending LFTs likely due to statin which resolved once statin was discontinued. Patient is now stable medically and neurologically for discharge to SAR and outpatient follow up in Stroke clinic.

Imaging/Tests:

2/7/19 Head CT without contrast IMPRESSION: 1. Left parieto-occipital wedge-shaped hypodensity stent with subacute left MCA infarct.] No evidence of intracranial hemorrhage. 2. Remote bilateral lacunar infarcts.3. Microvascular ischemia.

2/8/19 IMPRESSION: 1. There is interval development of focus of hyperdensity within the left MCA infarct territory, compatible with mild hemorrhagic transformation.2. No evidence of new intracranial infarct.

2/9/19 IMPRESSION: 1. No significant interval change from the prior head CT of 2/8/2019.2. Redemonstration

'rimary Care Provider Information **Kings County Hospital Center**

ient Name: Jean Francisque DOB: [redacted]7 Visit #: 2840513-1

This is a summary of your admission **for your Primary Care Provider.** Please share it with them.

of a subacute ischemic infarct in left MCA territory involving the left parietal and temporal lobes with evidence of mild petechial hemorrhage. The zone of infarction is not larger and no new hemorrhage is seen.3. Moderate chronic microvascular ischemia, cerebral atrophy and remote areas of infarction as above.

2/10/19 MRI Brain: IMPRESSION:1. Large area of recent ischemic infarction within the posterior left MCA division with moderate petechial hemorrhage.2. Cerebral atrophy and extensive chronic microvascular ischemic changes.3. Remote bilateral basal ganglia hemorrhagic infarct.

2/10/19 MRA of the brain:1. Mild/moderate stenosis of the midportion of the left MCA M1 segment and severe stenosis of one of the left MCA M2 branches proximally. There is a good filling of the left middle cerebral artery distal and proximal to these areas of stenosis.2. Nonvisualization of the right vertebral artery and the mid to proximal basilar artery, which could be secondary to combination of hypoplasia and atherosclerotic change. CTA can be obtained to better evaluate this finding, if clinically warranted.

2/10/19 MRA of the neck:1. No significant extracranial carotid artery stenosis.2. As above, nonvisualization of the right vertebral artery, which could be secondary to hypoplasia.

2/11/19 Extracranial/ cervical CTA: IMPRESSION:1. Mild left MCA M1 segment stenosis and occlusion of one of the left MCA M2 branches with good filling of the remaining left MCA branches.2. Moderate to pronounced narrowing of one of the right MCA M2 branches distally with good filling of the remainder of the right MCA branches.3. Poor visualization of the right vertebral artery below the C3 level, which could be secondary to hypoplasia. In addition, the right vertebral artery is only faintly visualized distally and there is poor visualization of the proximal basilar artery, likely due to a combination of hypoplasia intracranial atherosclerotic changes. Notably, there is good filling of the bilateral posterior cerebral arteries via the posterior communicating arteries (fetal origins as a normal variant).4. No significant

This is a summary of your admission **for your Primary Care Provider.** Please share it with them.

extracranial carotid or left vertebral artery stenosis.

2/11/19 bilateral lower extremity venous duplex scan: Impression: No deep venous thrombosis of the right or left lower extremity.

2/13/19 Pulmonary Artery CTA IMPRESSION: No evidence of central pulmonary embolus. Small amount of fluid in the right major fissure and subsegmental atelectasis in the lower lobes. Right ventricular wall musculature hypertrophy. Slight prominence of the left thyroid lobe.

2/24/19 Head CT without contrast IMPRESSION: 1. Interval development of patchy and serpiginous hyperdensities in the area of recent ischemic infarct of the left posterior temporoparietal lobes, likely representing hemorrhagic conversion of previously identified ischemic CVA. There is associated edema with mass effect on the left lateral ventricle and interval development of left-to-right midline shift measuring up to 2 mm.2. Redemonstration of lacunar infarcts of the bilateral basal ganglia and internal capsules.3. Right maxillary sinus disease.4. Status post right cataract surgery.5. Cortical atrophy and nonspecific periventricular white matter hypodensities compatible with chronic perivascular ischemic changes.

2/26/19 Head CT without contrast IMPRESSION: 1. Stable left parietal lobe/superior temporal lobe infarct with hemorrhagic transformation is stable leftward midline shift measuring 2.5 mm.2. No visible new acute infarct or hemorrhage.

2/26/19 IMPRESSION: Mild arthrosis of the medial and lateral compartment of the left knee.

3/4/19 RUQ abdomen US with Doppler: IMPRESSION:1. No evidence of cholelithiasis or cholecystitis. No evidence of biliary ductal dilation.2. Diffuse increased echogenicity of liver compatible with hepatic steatosis. No visible focal liver lesion.

TTE: Ejection Fraction = 55 to 60% (Normal) .There is mild concentric left ventricular hypertrophy. Grade I Diastolic Dysfunction is present.

Primary Care Provider Information **Kings County Hospital Center**

Patient Name: Jean Francisque DOB: [redacted] Visit #: 2840513-1

This is a summary of your admission **for your Primary Care Provider.** Please share it with them.

Pertinent Labs:

A1c: 10.2
LDL: 96.7

Discharge Physical Exam:
GEN: resting in bed, eyes open to verbal stimuli, minimal verbal outpt
Heart: S1, S2 present, no murmurs
Lungs: Normal respiratory effort. CTA bilaterally, no chest wall deformities
Abdomen: Soft, non-tender, non-distended, PEG present, no warmth or erythema present.
MSK: Joints grossly normal. No LE edema. Pt says "too hot" when left LE flexed at knee and hip.

Neuro:
Cognition: Opens eyes to vocal stimuli. Mildly attentive
Language: Minimal verbal output, answers appropriately with one word answers (ex: "yes/no") and occasionally with short statements (ex: "I'm fine").
CNs: PERRL, +VOR
Motor: partially able to follow commands. Increased tone in upper extremities bilaterally. Moves Right arm spontaneously anti-gravity. Increased tone in LE bilaterally
Sensation: unable to feel light touch in all extremities except RUE.

Discharge Medications:
Aspirin 81mg PEG Daily
Insulin Detemir 20u Q12H
Insulin Aspart 18u Q6H
Metoprolol Tartrate 100mg Q12H
Nystatin powder BID to groin
Ranitidine 150mg syrup PEG tube BID

Discharge instructions:
Call your doctor or return to the ED if there are any signs of bleeding.

3/6/19 Dietary recommendations per Speech and Language pathology:

Recommend: Puree and normal (thin) liquid diet as

Primary Care Provider Information **Kings County Hospital Center**

Patient Name: Jean Francisque DOB: [redacted] Visit #: 2840513-1

This is a summary of your admission **for your Primary Care Provider.** Please share it with them.

tolerated; Wean/hold PEG feeds and monitor PO intake/tolerance; F/u with Dietitian; General aspiration precautions; Feeding assistance; Monitor for bolus holding (pt benefitted from presenting next spoonful to trigger swallow); Check that oral cavity is clear at completion of meal; Sit upright 90 degrees; Oral care 2-3x/day. If pt is discharged to SAR, patient must f/u with SLP at that facility.

Follow-up Appointments:
Please follow up with your primary care doctor within 2 weeks of discharge.

Please follow up with Stroke clinic (E building first floor) on 3/29/19 at 2:30pm.

Primary Problem: Other cerebral infarction

Problems/Plans

Problem: Stroke with hemorrhagic conversion
Plan: CT head without contrast confirmed hemorrhagic conversion as of 2/27/19 CTH w/o contrast shows no change in hemorrhage size. restart ASA 81mg QD, c/w Lipitor 40 mg QD. Neurosurgery consulted- no intervention indicated. c/w Levemir 20U BID , fall precautions, PEG placement by IR
Summary:

Problem: Reversible causes of dementia
Plan: MRI brain, MRA head and neck showed L MCA stroke with petechial Hemorrhage - reversible work up negative
Summary:

Problem: #Code status
Plan: Code: Full code
Summary:

Problem: Persistent tachycardia
Plan: Venous dopplers negative, Metoprolol 100 mg BID, CTA negative for PE, Bcx NGTD, UA grossly negative. Pt will follow up with PCP for continued management
Summary:

Problem: fever
Plan: Afebrile since 2/15/19. Ucx with GPCs,

Primary Care Provider Information **Kings County Hospital Center**

tient Name: Jean Francisque DOB: [redacted] Visit #: 2840513-1

This is a summary of your admission **for your Primary Care Provider.** Please share it with them.

Bcx no growth to date, 2/26/19
Discontinue Amoxicillin-Clav 875-125 mg q12h, fluconazole 200mg QD

Summary:

Problem: Loose Stools
Plan: Resolved. Discontinued senna and colace.
Summary:

Problem: Diabetes
Plan: Aspart 18u Q6H, Levemir 20u AM and 20u PM. Pt will follow up with PCP for continued management
Summary:

Problem: Left knee pain with movement
Plan: L knee and hip Xrays completed, no fractures or effusions present. Mild arthrosis seen on imaging. Bilateral Knee xrays completed 3/6/19,mild tricompartmental osteoarthritis on imaging.
Summary:

Problem: Transaminitis
Plan: liver enzymes downtrending, please continue to monitor. Pt will follow up with PCP for continued management
Summary:

All Dxs Addressed Cerebral infarction, unspecified

Immunizations *PneumococcaL 13-Valent Conjugate Vaccine AKA -Prevnar 13

Discharge Provider: Hasan,Abida, MD
Attending: Law,Susan, DO
Unit: D2S - Medicine
Call-back #: (718) 245 - 7156

Pending Microbiology Results

Blood Culture	16 Feb 19	1230	in progress
Urine Culture	18 Feb 19	2118	in progress
Urine Culture	24 Feb 19	1511	in progress

RUTLAND NURSING H

ADVANCE DIRECTIVES

Resident's Name: Jean Francisque

Resident Representative's Name: Carmelle Gladys Francisque

Room Number: 1013B

Date of Admission: 3/6/2019

1) Was the resident admitted with an Advance Directive?

( ) Yes **(X) No (Skip to question #4)**

2) Type of Advance Directive resident was admitted with (check all that apply).

( ) Living Will

( ) Durable power of Attorney for Health Care

( ) Health Care Proxy

( ) DNR ( ) DNI

3) Were copies of Advance Directives placed on chart?

( ) Yes ( ) No

If no, who has Advance Directive?

Name: _____ **Phone #:** _____

4) Resident was provided information on Advance Directives on date 3/12/19

5) Did the resident request institution of an Advance Directive?

( ) Yes ( ) No (Type)

If No, check all that apply:

( ) Resident is unable to comprehend implication of Advance Directive.

( ) Resident unable to comprehend implication of Advance Directive and

PHYSICIAN'S ORDERS

10 WEST
REPORT DATE : 04/03/19

1

MEDICATIONS	HOUR	ORDERS
ASPIRIN EC 81 MG TABLET TAKE ONE TABLET ORALLY EVERY DAY FOR CVA	06532194 9 AM	
ERGOCALCIFEROL 50,000 UNI TAKE ONE CAPSULE ORALLY EVERY WEDNESDAY FOR VIT D DEFICIENCY	06532196 9 AM	
ISONIAZID 300 MG TABLET TAKE ONE TABLET VIA GT EVERY DAY (TB) (START 3/20/19 FOR 9 MONTHS)	06534114 9 AM	
PYRIDOXINE 50 MG TABLET TAKE ONE TABLET VIA GT EVERY DAY SUPPLEMENT (START 3/20/19 FOR 9 MONTHS)	06534117 9 AM	
LEVEMIR 100 UNITS/ML VIAL INJECT 42 UNITS SUBCUTANEOUSLY EVERY 12 HOURS FOR (DIABETES)	06532198 __ AM __ PM	
METOPROLOL TARTRATE 100 TAKE ONE TABLET VIA GT EVERY 12 HOURS FOR HTN. HOLD IF BP<110/60, HR<60	06531166 __ AM __ PM	
NYSTATIN 100,000 UNIT/GM APPLY TO GROIN TWICE A DAY	06531187 9 AM 5 PM	
RANITIDINE 150MG/10ML SOL TAKE 10MLVIA PEG TWICE A DAY FOR GI PPX	06531184 9 AM 5 PM	
ACETAMINOPHEN 325 MG TABL TAKE TWO TABLETS ORALLY EVERY 8 HOURS FOR LEFT KNEE PAIN	06532772 5 AM 1 PM 9 PM	

4/6/19

STOCK 502434 FORM A-70

MEDS REVIEWED BY: DATE:

PHYSICIAN'S SIGNATURE: DATE: 4/05/18

CHARTING FOR: 04/03/19 THROUGH: 04/03/19 PAGE 1 OF 2

Physician: WUBSHET, BERHANE

Telephone No.: 516-432-1784

Medical Record No.: 370519

Alt. Physician:

Alt. Telephone: 4/6/19

Allergies: NO KNOWN ALLERGIES

Diagnosis:

Medicaid Number:

Medicare Number: 101541756

Complete Entries Checked: By: Title: 4/5/19 Late:

RESIDENT

D.O.B. [redacted] Sex M Room # W1013-B Patient Code 370519 Admission Date 03/06/1

12 AM

FORM A-70 STOCK 502434

Ro[illegible] 4/6/19

IDS REVIEWED BY: DATE:	PHYSICIAN'S SIGNATURE	DATE: 4/5/19	
ARTING FOR 04/03/19	THROUGH 04/03/19	PAGE 2 OF 2	
ysician WUBSHET, BERHANE		Telephone No. 516-432-1784	Medical Record No. 370519
. Physician		Alt. Telephone	
lergies NO KNOWN ALLERGIES			
ignosis			
Medicaid Number	Medicare Number 101541756	Complete Entries Checked: By: Title: Date:	

RESIDENT FRANCISQUE, JEAN	D.O.B. [redacted]	Sex M	Room # W1013-B	Patient Code 370519	Admission Date 03/06/19		

☐ KINGSBROOK JEWISH MEDICAL CENTER
☐ RUTLAND NURSING HOME

BROOKLYN, N.Y.

INTERIM DOCTOR'S ORDERS

AUTHORIZATION IS HEREBY GIVEN FOR THE PHARMACY TO DISPENSE THESE PRESCRIPTIONS BY THEIR BIOAVAILABLE EQUIVALENT IN ACCORDANCE WITH THE HOSPITAL FORMULARY.

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

DOCTOR: START A NEW SECTION WITH EAC
NURSE: ALL ORDERS MUST BE VERI... BY NURSE ON FOLLOWING TWO SHIFTS.

DATE	TIME
3/19	19

- INH 300 mgs Via GT tube Daily (+ Quantiferon TB kit) / 9 months
- B6 50 mgs Via GT Daily (Suppt) / 9 months

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift: A Moore	Date / Time: 4/4/19	
Third Shift:	Date / Time: 3/20/19 4p-7a	Prescriber Signature:

INITIAL NURSE: 3-4
DATE / TIME: 3/20/19
FAXED ON:

DATE	TIME
3/20/19	

Per Dr Wubshet
D/C Tegas catheter

INITIAL NURSE:

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time:	
Third Shift: Sept 4p-7a	Date / Time: 3/20/19 11p-7a	Prescriber Signature:

DATE / TIME:
FAXED ON:

DATE	TIME
4/9	19

D/C previous order for Ergocalciferol
Start Ergocalciferol 8000 unit/ml
Give 6 ml (48000 units) Via GT weekly on Mondays for 12 weeks (Vit D def)

Boyle Co

INITIAL NURSE:
4/9/19
DATE / TIME:

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time: 4/9/19	
Third Shift: Sept 4p-7a	Date / Time: 4/9/19 11p-7a	Prescriber Signature:

7-3.
FAXED ON:

DO NOT USE THIS SHEET UNLESS THE NUMBER APPEARING IN RED MATCHES THE NEXT BLANK SECTION

FORM X00435 REV. 4/11

☐ KINGSBROOK JEWISH MEDICAL CENTER
☐ RUTLAND NURSING HOME

BROOKLYN, N.Y.

INTERIM DOCTOR'S ORDERS

AUTHORIZATION IS HEREBY GIVEN FOR THE PHARMACY TO DISPENSE THESE PRESCRIPTIONS BY THEIR BIOAVAILABLE EQUIVALENT IN ACCORDANCE WITH THE HOSPITAL FORMULARY.

FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT# 1643155

DOCTOR: START A NEW SECTION WITH EACH ...
NURSE: ALL ORDERS MUST BE VERIFIED BY NURSE ON FOLLOWING TWO SHIFTS.

DATE	TIME	
4/8	2019	Re-certification for skilled ST evaluation & treatment 3 Sx/wk for 4 weeks for treatment of speech sound production, language comprehension/expression & swallow dysfunction and/or oral function for feeding.

INITIAL NURSE

Must include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time:	
Third Shift:	Date / Time:	Prescriber Signature:

DATE / TIME

FAXED ON

DATE	TIME	

INITIAL NURSE

Must include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time:	
Third Shift:	Date / Time:	Prescriber Signature:

DATE / TIME

FAXED ON

DATE	TIME	

INITIAL NURSE

Must include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time:	
Third Shift:	Date / Time:	Prescriber Signature:

DATE / TIME

FAXED ON

☐ KINGSBROOK JEWISH MEDICAL CENTER
☐ RUTLAND NURSING HOME

BROOKLYN, N.Y.

INTERIM DOCTOR'S ORDERS

AUTHORIZATION IS HEREBY GIVEN FOR THE PHARMACY TO DISPENSE THESE PRESCRIPTIONS BY THEIR BIOAVAILABLE EQUIVALENT IN ACCORDANCE WITH THE HOSPITAL FORMULARY.

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

DOCTOR: START A NEW SECTION WITH EACH N[EW ORDER]
NURSE: ALL ORDERS MUST BE VERIFIED [FOLLOWING TWO SHIFTS.]

DATE	TIME	ORDER	
4/4/19		Recertification for Skilled PT Evaluation and treatment for 4 wks 5-7 days for therapeutic ex, therapeutic activities, neuromuscular re-education and gait training	

Must include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift: [signature]	Date / Time: 4/4/19 3-11	
Third Shift:	Date / Time:	Prescriber Signature: [signature]

INITIAL NURSE: [initials]
DATE / TIME:
FAXED ON:

DATE	TIME	ORDER
4/5/19	2:40pm	Recertification for skilled occupational therapy 5-7x/week x 4 weeks to address self-care & ADL

Must include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time:	
Third Shift:	Date / Time:	Prescriber Signature: [signature]

INITIAL NURSE: [initials]
DATE / TIME:
FAXED ON:

DATE	TIME	ORDER
4/5/19		CBC, CMP tue Monday mod Renal

Must include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time:	
Third Shift:	Date / Time:	Prescriber Signature: [signature]

INITIAL NURSE: [initials]
DATE / TIME: 4/5/19
FAXED ON:

DO NOT USE THIS SHEET UNLESS THE NUMBER APPEARING IN RED MATCHES THE NEXT BLANK SECTION

FORM X00435 REV. 4/11

☐ KINGSBROOK JEWISH MEDICAL CENTER
☐ RUTLAND NURSING HOME

BROOKLYN, N.Y.

FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

INTERIM DOCTOR'S ORDERS

AUTHORIZATION IS HEREBY GIVEN FOR THE PHARMACY TO DISPENSE THESE PRESCRIPTIONS BY THEIR BIOAVAILABLE EQUIVALENT IN ACCORDANCE WITH THE HOSPITAL FORMULARY.

DOCTOR: START A NEW SECTION WITH EACH NEW SET OF ORDERS
NURSE: ALL ORDERS MUST BE VERIFIED BY NURSE ON FOLLOWING TWO SHIFTS.

DATE	TIME	ORDER	
3/7/19		Skilled Pt Evaluation and treatment for 4 wks, 5-7 days/wk for therapeutic exs therapeutic activities, neuromuscular reeducation and gait training	INITIAL NURSE: [illegible]

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order			
Second Shift: A [illegible]	Date / Time: [illegible] 7-3		DATE / TIME
Third Shift: [illegible]	Date / Time: 3/8/19 (11-7A)	Prescriber Signature: [illegible]	FAXED ON

DATE	TIME	ORDER	
3/7/19		Skilled OT Evaluation + Treatment for 4 wks, 5-7 days for therapeutic activities, therapeutic exercises, Neuromuscular re-education, Selfcare training, wheelchair mgmt training to address Generalized muscle weakness	INITIAL NURSE: [illegible]

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order			
Second Shift: A [illegible]	Date / Time: 3/4/19		DATE / TIME
Third Shift: [illegible]	Date / Time: 3/8/19 (11p-7A)	Prescriber Signature: [illegible]	FAXED ON

DATE	TIME	ORDER	
3/7/19		Pt is dependent in transfers out bed to standard W/C ~~[illegible]~~ [illegible]	INITIAL NURSE: [illegible]

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order			
Second Shift: [illegible]	Date / Time: 3/7/19 3-11		DATE / TIME
Third Shift: [illegible]	Date / Time: 3/8/19 (11p-7A)	Prescriber Signature: [illegible]	FAXED ON

DO NOT USE THIS SHEET UNLESS THE NUMBER APPEARING IN RED MATCHES THE NEXT BLANK SECTION

FORM X00435 REV. 4/11

☐ KINGSBROOK JEWISH MEDICAL CENTER
☐ RUTLAND NURSING HOME

BROOKLYN, N.Y.

INTERIM DOCTOR'S ORDERS

AUTHORIZATION IS HEREBY GIVEN FOR THE PHARMACY TO DISPENSE THESE PRESCRIPTIONS BY THEIR BIOAVAILABLE EQUIVALENT IN ACCORDANCE WITH THE HOSPITAL FORMULARY.

FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

DOCTOR: START A NEW SECTION WITH EACH NEW SET OF ORDERS, USE ONLY ONE LINE PER ORDER.
NURSE: ALL ORDERS MUST BE VERIFIED BY NURSE ON FOLLOWING TWO SHIFTS.

DATE	TIME	
3/11	19	Anemia profile stool for OB x 2 D/C current order for Lovenox Start Lovenox 90 units SC Q 12 hrs (DH) LFT, Hepatitis profile on 3/15/19

INITIAL NURSE
DATE / TIME 3/11/19 4:25 PM

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order
Second Shift: A Moore Date / Time: 4/4/19
Third Shift: [illegible] Date / Time: 3/12/19 (illegible) Prescriber Signature: [illegible]

FAXED ON

DATE	TIME	
3/12	19	Tylenol 650mgs p.o Q 8hrs for (L) knee pain Voltaren 1% gel – massage in (L) knee twice daily / 15 days

INITIAL NURSE
DATE / TIME 3/12/19

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order
Second Shift: A Moore Date / Time: 4/4/19
Third Shift: [illegible] Date / Time: 3/12/19 11:59 PM Prescriber Signature: [illegible]

FAXED ON

DATE	TIME	
3/12/19	9:30	To Dr Wubshet Telephone Renals Doppler (L) leg

INITIAL NURSE
DATE / TIME 3/12/19

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order
Second Shift: A Moore Date / Time: 4/4/19
Third Shift: [illegible] Date / Time: 3/13/19 11:59 PM Prescriber Signature: [illegible]

FAXED ON

DO NOT USE THIS SHEET UNLESS THE NUMBER APPEARING IN RED MATCHES THE

FORM X00435 REV. 4/11

☐ KINGSBROOK JEWISH MEDICAL CENTER
☐ RUTLAND NURSING HOME

BROOKLYN, N.Y.

INTERIM DOCTOR'S ORDERS

AUTHORIZATION IS HEREBY GIVEN FOR THE PHARMACY TO DISPENSE THESE PRESCRIPTIONS BY THEIR BIOAVAILABLE EQUIVALENT IN ACCORDANCE WITH THE HOSPITAL FORMULARY.

FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted]7 M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

DOCTOR: START A NEW SECTION WITH EA [illegible] USE ONLY BALL POINT PEN.
NURSE: ALL ORDERS MUST BE VERIFIED BY NURSE ON FOLLOWING TWO SHIFTS.

DATE	TIME	
3/7	12:15p	T/O Dr Wubshet MD to Dr Bress PharmD ① Stop Aspirin ② Clarification: Hold parameters for metoprolol - hold for BP < 110/60 or HR < 60

Kathryn Bress, B.S., Pharm.D.
~~Pharmacy Practice Resident (PGY-I)~~
Department of Pharmacy
Pager: 894, Ext. 6659

Must include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift: Stacey	Date / Time: 3/7/19 3-11	Prescriber Signature: [signature]
Third Shift: [signature]	Date / Time: 3/8/19 qpm	

INITIAL NURSE
DATE / TIME 3/7/19 7:3
FAXED ON

DATE	TIME	
3/11/19		Skilled ST evaluation & treatment 3-5x/wk for 4 weeks for evaluation & treatment of speech-sound production, language comprehension & expression & bedside swallow evaluation & treatment of swallow dysfunction and/or oral function for feeding

INITIAL NURSE

Must include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift: A Mook	Date / Time: 4/4/1923	Prescriber Signature: [signature]
Third Shift:	Date / Time:	

DATE / TIME 3/11/19 4:10 PM
FAXED ON

DATE	TIME	
3/11	12PM	T/O MD Wubshet to Dr. Liu. PharmD 1. Aspirin 81 mg PO qdaily for CVA 2. Start ergocalciferol 50,000 units PO qweekly on Wednesdays x 12 weeks for vitamin D deficiency

Catherine Liu, Pharm.D., BCPS
Clinical Pharmacy Specialist-Geriatrics
Department of Pharmacy
Pager: 560, Ext. 5810

Must include Diagnosis / Reason for Use: Expired 11 back

Nursing Verification of Order		
Second Shift: A Mook	Date / Time:	Prescriber Signature: [signature]
Third Shift: [signature]	Date / Time: 3/12/19 1pm	

INITIAL NURSE
DATE / TIME
FAXED ON

DO NOT USE THIS SHEET UNLESS THE NUMBER APPEARING IN RED MATCHES THE NEXT BLANK SECTION

FORM X00435 REV. 4/11

☐ KINGSBROOK JEWISH MEDICAL CENTER
☐ RUTLAND NURSING HOME

BROOKLYN, N.Y.

INTERIM DOCTOR'S ORDERS

AUTHORIZATION IS HEREBY GIVEN FOR THE PHARMACY TO DISPENSE THESE PRESCRIPTIONS BY THEIR BIOAVAILABLE EQUIVALENT IN ACCORDANCE WITH THE HOSPITAL FORMULARY.

DOCTOR: START A NEW SECTION WITH EA
NURSE: ALL ORDERS MUST BE VER

03/06/19
RNH 0370519
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

DATE	TIME	
4/4/19		Re-Certification for resident to recieve OT Services for a dx of muscle weakness for 5-6 x ca week for 45mins. OT will provide Therapeutic exercise, Self care tasks, w/c management, Cognitive re-training Neuro muscular re-education

INITIAL NURSE

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time:	
Third Shift:	Date / Time:	Prescriber Signature:

DATE / TIME

FAXED ON

DATE	TIME	

INITIAL NURSE

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time:	
Third Shift:	Date / Time:	Prescriber Signature:

DATE / TIME

FAXED ON

DATE	TIME	

INITIAL NURSE

Must Include Diagnosis / Reason for Use:

Nursing Verification of Order		
Second Shift:	Date / Time:	
Third Shift:	Date / Time:	Prescriber Signature:

DATE / TIME

FAXED ON

FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

3/6/19 PRINT DATE

Physician's Order

3/19 MONTH / YEAR

MEDICATION ORDERS

RUTLAND NURSING HOME

☑ NEW ADMISSION ☐ RE ADMISSION

CURRENT PLAN OF CARE
PG 1 OF 2

PHYSICIAN CURRENT ORDERS

1) To Dr Wubshet / Joseph RNS

2) Aspirin 81 mg PEG
DX: PAD, CAD Prophylaxis

3) Metoprolol 100 mg PEG BID & 12 hrs GT (HTN) For BP < 110/60 HR < 60
DX:

4) Ranitidine 150 mg Syrup PEG Tube BID (GI Prophylaxis
DX:

5) Insulin Levemir 20U @ 12 hrs.
DX: E0011

6) Insulin Aspart 18U @ 6 hrs. 1001
DX:

7) Nystatin Powder BID to Groin. Cash
DX:

8) Texas cath in Place. ?
DX:

9) DVT - Sleeve Compressor.
DX:

10) Insulin Aspart Correction Low dose TID.
DX: NC meals

See diet Sheet

DIET: ____REGULAR ____NAS ____NCS
____1800 CAL ____LOW FAT / LOW CHOLESTEROL
____RENAL

CONSISTENCY: ____REGULAR ____PUREED ____CHOPPED
____HONEY ____NECTAR

____TUBE FEEDING - SEE SEPARATE TUBE FEEDING ORDER NOW

ACTIVITY LEVEL – AT
– OOB TO W/E RECLINER/GERICHAIR

PERMISSION TO LEAVE PREMISES: ____YES WITH ESCORT
____NO

WEIGHT ____ MONTHLY ✓ WEEKLY X 4 WEEKS, THEN MONTHLY

CONSULTS: ____DENTAL ____OPHTH ____PSYCH ____PODIATRY
____OTHER

LAB ORDERS CBC, CMP, TSh, Lipid Profile, 25-Hydroxy Vit D Level, Quantiferon TB Test, UA, EKG, CXR, HbA1c.

REHABILITATION:
____PT EVAL
____OT EVAL
____SPEECH EVAL
____RESP THERAPY ____OXYGEN

OTHER V/S & Shift x 3 days.
Fall and Aspiration precaution

DNR: ____ DNI: ____ HCP: ____ LW: ____

Crush all meds and give via G.T.

I CERTIFY THE BELOW NAMED RESIDENT IS IN NEED OF CONTINUED (NF) CARE.

PHYSICIAN Bu mck DATE 3/7/19

☐ DISPENSE AS WRITTEN — THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITE D A W IN THE BOX

PEG CARE

___ CLEAN GT with Normal Saline, apply DSD daily
___ CRUSH MEDS & GIVE VIA GT

PICKED UP BY: Jeanney	DATE: 3/7/19	TIME: 7
PICKED UP BY:	DATE:	TIME:
REVIEWED BY:	DATE:	TIME:
REVIEWED BY:	DATE: 3/14/19	TIME: 7:5

ALLERGIES: NKA

DIAGNOSIS: PR: Stroke with hemorrhagic Conversion PEG replacement 2/22/19
Sec: HTN, DM.

PATIENT NAME	NS/ROOM/BED	D.O.B.	SEX	PHYSICIAN NAME
Francisque, Jean	1013B	09/16/47	M	Dr Wubshet

PO-1

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
Phy 917-325-1931
[redacted]7 M CATHOLIC TW 1013B
MONTHLY LTCM/WUBSHET, B.

PRINT DATE

ACCNT#: 1643155

MEDICATION ORDERS

PHYSICIAN CURRENT ORDERS

DX:
DX:
DX:
DX:
DX:
DX:
DX:
DX:
DX:
DX:

RUTLAND NURSING HOME

PG 1 OF 1

DIET: See diet sheet

ADVANCE DIRECTIVES: DNR___ HCP___ LW___

ACTIVITY Ai

___ OOP

WEIGHT ___ MONTHLY ___ WEEKLY ___

___ REHAB

___ RESPIRATORY

___ OTHER

SSE PRN of no BM 7ED
Aspiration / Fall precautions
Clean CT Site c NS Cover c DSG Daily

I CERTIFY THE BELOW NAMED RESIDENT IS IN NEED IF CONTINUED (NF) CARE

☐ THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITE D A W IN THE BOX
DISPENSE AS WRITTEN

PICKED UP BY: [illegible]	DATE: 4/5/19	TIME: 9P
PICKED UP BY: [illegible]	DATE: 4/6/19	TIME: 7A
REVIEWED BY:	DATE:	TIME:
REVIEWED BY: Joseph LPN	DATE: 4/5/19	TIME: 11P

PHYSICIAN [illegible] DATE 4/5/19

ALLERGIES:

DIAGNOSIS:

PATIENT NAME	NS/ROOM/BED	D.O.B.	SEX	PHYSICIAN NAME

1/4/19

KINGSBROOK
JEWISH MEDICAL CENTER

FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TV 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

TF+PO

Rutland Nursing Home Oral Nutrition Order Form

Please check the appropriate diet for the Resident. Combination diets require checking all applicable diets, including consistency modification. Any diet change requires a new order form. Please send yellow copy to Food and Nutrition Services Department and pink copy to Pharmacy Department.

Standard Diets:
___ Regular ___ Kosher ___ High Fiber ___ Lactose Free ___ Vegetarian ___ Pediatric
___ No Added Salt (NAS) ✓ Recreational PO _____

Consistency Modification (Regular consistency ordered unless one of below selected):
___ Chopped ✓ Puree → Full Tray at Lunch meal ONLY ___ Modified Regular
___ Mixed Consistency per Speech
Thickened Liquids: ___ Nectar ___ Honey

aspiration precautions

Therapeutic Diets:
___ NPO ___ Full Liquid ___ Clear Liquid ___ Neutropenic Diet

Cardiac:
___ 2 gram Sodium (2g Na) ___ Cardiac (2g Na, LFLC)

Carbohydrate Consistent Diets:
___ 1,500 Calories/200gCHO ___ 1,800 Calories/250g CHO ___ 2,000 Calories/275g CHO

Renal Diets:
___ Pre-dialysis 60 (60g protein, 2g K^+, 1g Phosphorus, 2g Na)
___ Pre-dialysis 80 (80g protein, 2g K^+, 1g Phosphorus, 2g Na)
___ Dialysis (90g protein, 2g K^+, 1g Phosphorus, 2g Na)
___ 60g Protein Diet (No other restriction)

Fluid Restriction: ___ 1000 mL ___ 1200 mL ___ 1500 mL

___ **Snacks:** _____ AM _____ PM _____ HS

Oral Supplements:
___ Ensure Enlive: 237 mL ____ times daily (___ chocolate, ___vanilla, ____ strawberry)
___ Ensure Pudding: 120 mL _____ times daily (_____ chocolate, _____ vanilla)
___ Ensure Clear: 237 mL _____ times daily (_____ apple, _____ mixed berry)
___ Ensure Compact 118 mL (Nectar Thick) _____ times daily (chocolate only)
___ Glucerna Shake: 237 mL ____ times daily (__chocolate, __vanilla,__strawberry,__butterpecan)
___ Nepro: 237 mL _____ times daily (___vanilla, ___ mixed berry)
___ Proform Protein Supplement 30 mL (2 Tablespoons) _____ times daily
___ Suplena: 237 mL _____ times daily (vanilla only)
___ Two Cal HN: 237 mL _____ times daily (____vanilla, ____ butter pecan)
___ Vital 1.0 Cal: 237 mL _____ times daily (vanilla only)
___ Other: _____

Parenteral/Enteral Nutrition: see separate TPN Order Form or Enteral Nutrition Order Form

Medical Provider's Signature Ben Nazarian **Date/Time** 4/4/19
Nurse's Signature Jeney **Date/Time** 4/4/19
A Mu 4/5/19

WHITE-MEDICAL CHART YELLOW-FOOD & NUTRITION SERVICES PINK-PHARMACY
4-2369 REVISED 2/18

KINGSBROOK
JEWISH MEDICAL CENTER

FRANCISQUE ,JEAN M 71
1256 WUBSHET, BERHANE,
VAS PT#: 11045967 DOB: [redacted]
MR#: 0370519 PH#:
REG DT: 03/13/19 TIME 09:34

TF + PO

Rutland Nursing Home Oral Nutrition Order Form

Please check the appropriate diet for the Resident. Combination diets require checking all applicable diets, including consistency modification. Any diet change requires a new order form. Please send yellow copy to Food and Nutrition Services Department and pink copy to Pharmacy Department.

Standard Diets:

___ Regular ___ Kosher ___ High Fiber ___ Lactose Free ___ Vegetarian ___ Pediatric

___ No Added Salt (NAS) ✓ Recreational PO snacks (Lunch only)

Consistency Modification (Regular consistency ordered unless one of below selected): Example

___ Chopped ✓ Puree ___ Modified Regular Pudding, mash apple, potato

___ Mixed Consistency per Speech Juice, Hot Cereal, gravy

Thickened Liquids: ___ Nectar ___ Honey Thin Liquid

Aspiration Precautions

Therapeutic Diets:

___ NPO ___ Full Liquid ___ Clear Liquid ___ Neutropenic Diet

Cardiac:

___ 2 gram Sodium (2g Na) ___ Cardiac (2g Na, LFLC)

Carbohydrate Consistent Diets:

___ 1,500 Calories/200gCHO ___ 1,800 Calories/250g CHO ___ 2,000 Calories/275g CHO

Renal Diets:

___ Pre-dialysis 60 (60g protein, 2g K^+, 1g Phosphorus, 2g Na)

___ Pre-dialysis 80 (80g protein, 2g K^+, 1g Phosphorus, 2g Na)

___ Dialysis (90g protein, 2g K^+, 1g Phosphorus, 2g Na)

___ 60g Protein Diet (No other restriction)

Fluid Restriction: ___ 1000 mL ___ 1200 mL ___ 1500 mL

___ **Snacks:** ___ AM ___ PM ___ HS

Oral Supplements:

___ Ensure Enlive: 237 mL ___ times daily (___ chocolate, ___ vanilla, ___ strawberry)
___ Ensure Pudding: 120 mL ___ times daily (___ chocolate, ___ vanilla)
___ Ensure Clear: 237 mL ___ times daily (___ apple, ___ mixed berry)
___ Ensure Compact 118 mL (Nectar Thick) ___ times daily (chocolate only)
___ Glucerna Shake: 237 mL ___ times daily (__chocolate, __vanilla, __strawberry, __butterpecan)
___ Nepro: 237 mL ___ times daily (___vanilla, ___ mixed berry)
___ Proform Protein Supplement 30 mL (2 Tablespoons) ___ times daily
___ Suplena: 237 mL ___ times daily (vanilla only)
___ Two Cal HN: 237 mL ___ times daily (___vanilla, ___ butter pecan)
___ Vital 1.0 Cal: 237 mL ___ times daily (vanilla only)
___ Other: ___

Parenteral/Enteral Nutrition: see separate TPN Order Form or Enteral Nutrition Order Form

Medical Provider's Signature [signature] **Date/Time** ___

Nurse's Signature [signature] **Date/Time** 3/18/19

TO Dr [signature] A. Moot 4/4/19

WHITE-MEDICAL CHART / YELLOW-FOOD & NUTRITION SERVICES PINK-PHARMACY

4-2369 REVISED 2/18

KINGSBROOK
JEWISH MEDICAL CENTER

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted]7 M CATHOLIC TW .013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

Rutland Nursing Home Oral Nutrition Order Form TF + PO

Please check the appropriate diet for the Resident. Combination diets require checking all applicable diets, including consistency modification. Any diet change requires a new order form. Please send yellow copy to Food and Nutrition Services Department and pink copy to Pharmacy Department.

Standard Diets:

___ Regular
___ 2,000 Calories/275g Carbohydrate (CHO)
___ 1,800 Calories/250g CHO
___ No Added Salt (NAS)
___ Dialysis (2g K^+, Low Phosphorus, NAS)
___ Fluid Restriction: ___ 1000 mL ___ 1200 mL ___ 1500 mL
___ Kosher
___ High Fiber
___ Lactose Free
___ Vegetarian
___ Pediatric

Consistency Modification (Regular consistency ordered unless one of below selected):

___ Chopped
___ Modified Regular
__x__ Puree Full Tray at Lunch meal only.
Thickened Liquids: ___ Nectar ___ Honey
aspiration precaution

Specialty Diets:

___ NPO
___ Full Liquid
___ 2 gram Sodium (2g Na)
___ 1,500 Calories/200g CHO
___ BRAT (Bananas, Rice, Applesauce, and Tea)
___ Pre-dialysis 60 (60g protein, 2g K^+, Low Phosphorus, 2g Na)
___ Pre-dialysis 80 (80g protein, 2g K^+, Low Phosphorus, 2g Na)
___ Low Fat/Cholesterol (LFLC)
___ Clear Liquid
___ 60g Protein
___ 2g K^+, Low Phosphorus
___ Cardiac (2g Na, LFLC)

Oral Supplements:

___ Ensure Clinical Strength: 237 mL ___ times daily (___ chocolate, ___vanilla, ____ strawberry)
___ Ensure Pudding: 120 mL _____ times daily (_____ chocolate, _____ vanilla)
___ Glucerna Shake: 237 mL _____ times daily (___ chocolate, ___ vanilla, ____ strawberry)
___ Nepro: 237 mL _____ times daily (vanilla only)
___ Pro-Stat Sugar-free 64 Protein Supplement 30 mL (2 Tablespoons) _____ times daily
___ Suplena: 237 mL _____ times daily (vanilla only)
___ Two Cal HN: 237 mL _____ times daily (vanilla only)
___ Vital 1.0 Cal: 237 mL _____ times daily (vanilla only)
___ Other: _____

___ Nourishment (Snack): _____ AM _____ PM _____ HS
Comments: _____

___ Tube fed + oral diet (see Enteral Nutrition Order Form for tube feeding order)
Parenteral/Enteral Nutrition: see separate TPN Order Form or Enteral Nutrition Order Form

Medical Provider's Signature _____ **Date/Time** 4/5/19
Nurse's Signature _____ **Date/Time** 4/5/19

WHITE-MEDICAL CHART YELLOW-FOOD & NUTRITION SERVICES PINK-PHARMACY
4-2369 REVISED 2/11

KINGSBROOK
JEWISH MEDICAL CENTER

RUTLAND

PRESSU[RE]
WOUND [CARE]

KNH 030519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

STAGE 1

TREATMENT PROTOCOL:
SKINTEGRITY WOUND CLEANSER
SUREPREP
SURESITE DRESSING (7 DAY)
BARRIER CREAM TO SURROUNDING SKIN

SITES:
☐ R HIP ☐ R EAR ☐ R ANKLE ☐ R HEEL
☐ L HIP ☐ L EAR ☐ L ANKLE ☐ L HEEL
☐ R UPPER BACK ☐ L UPPER BACK ☐ SACRUM ☐ OCCUIPUT
☐ OTHER SITES:
☐ STAGE 1 PROTOCOL
☐ OTHER WOUND CARE ORDERS:

STAGE 2:

TREATMENT PROTOCOL:
SKINTEGRITY WOUND CLEANSER
SUREPREP
HYDROCOLLOID DRESSING (5 DAY)

SITES:
☐ R HIP ☐ R EAR ☐ R ANKLE ☐ R HEEL
☐ L HIP ☐ L EAR ☐ L ANKLE ☐ L HEEL
☐ R UPPER BACK ☐ L UPPER BACK ☐ SACRUM ☐ OCCIPUT
☐ OTHER SITES:
☐ STAGE 2 PROTOCOL
☐ OTHER WOUND CARE ORDERS:

STAGE 3:

TREATMENT PROTOCOL:
SKINTEGRITY WOUND CLEANSER
SUREPREP
LOW EXUDATE HYDROGEL
HI EXUDATE ALGINATE
BARRIER DRESSING (DAILY)
UNSTAGEABLE:
SLOUGH/ESCHAR USE TENDERWET

SITES:
☐ R HIP ☐ R EAR ☐ R ANKLE ☐ R HEEL
☐ L HIP ☐ L EAR ☐ L ANKLE ☐ L HEEL
☐ R UPPER BACK ☐ L UPPER BACK ☐ SACRUM ☐ OCCIPUT
☐ OTHER SITES:
☐ WOUND CARE CONSULT (COMPLETE CONSULT SHEET)
☐ STAGE 3 PROTOCOL
☐ COLLAGENASE ☐ SILVERSORB ☐ ARGLAES POWDER ☐ MEDIFIL
☐ PURACOL
☐ OTHER WOUND CARE ORDERS:

STAGE 4:

TREATMENT PROTOCOL:
SKINTEGRITY WOUND CLEANSER
SUREPREP
LOW EXUDATE HYDROGEL
HI EXUDATE ALGINATE
BARRIER DRESSING (DAILY)
UNSTAGEABLE:
SLOUGH/ESCHAR USE TENDERWET

SITES:
☐ R HIP ☐ R EAR ☐ R ANKLE ☐ R HEEL
☐ L HIP ☐ L EAR ☐ L ANKLE ☐ L HEEL
☐ R UPPER BACK ☐ L UPPER BACK ☐ SACRUM ☐ OCCIPUT
☐ OTHER SITES:
☐ WOUND CARE CONSULT (COMPLETE CONSULT SHEET)
☐ STAGE 4 PROTOCOL
☐ COLLAGENASE ☐ SILVERSORB ☐ ARGLAES POWDER ☐ MEDIFIL
☐ PURACOL
☐ OTHER WOUND CARE ORDERS:

SKIN TEARS:

TREATMENT PROTOCOL:
SKINTEGRITY WOUND CLEANSER
SUREPREP
HYDROGEL DRESSING
BARRIER DRESSING (3 DAY)

SITES:
☐ R HIP ☐ R EAR ☐ R ANKLE ☐ R HEEL
☐ L HIP ☐ L EAR ☐ L ANKLE ☐ L HEEL
☐ R UPPER BACK ☐ L UPPER BACK ☐ SACRUM ☐ OCCIPUT
☐ OTHER SITES:
☐ SKIN TEAR PROTOCOL ☐ OTHER WOUND CARE ORDERS:

OTHER WOUND CARE ORDERS: Offload Lt Heel on pillow

[signature] 3/8/19

PHYSICIAN'S SIGNATURE DATE TIME NURSES'S SIGNATURE DATE TIME

Dr Wubshet [signature] 3/7/19 4pm

White Copy - Chart Yellow Copy - Pharmacy

KJMC - 5002 8/11

[signature] 4/4/19 [signature] 3/18/19 [signature] 3/11/19

RNH 03/05/19 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

KINGSBROOK
JEWISH MEDICAL CENTER

Rutland Nursing Home Enteral Nutrition Order Form

Any change in enteral feeding requires a new order form. Please send yellow copy to Food and Nutrition Services Department and pink copy to Pharmacy Department.

Adult Enteral Formulas

___ Jevity 1.2	____ Jevity 1.5	___ Osmolite 1.2
___ Glucerna 1.0	X Glucerna 1.2	___ Promote with Fiber
___ Perative	___ Pivot 1.5	___ Two Cal HN
___ Nepro	___ Suplena	___ Vital 1.2

___ Vivonex (for milk protein allergy) ___ Other _____

Total formula volume/24 hours:
___ 1000 mL ✓ 1500 mL ___ 2000 mL ___ Other _____

Check one of the following:
✓ Continuous feeding at 55 mL/hr (not to exceed 99 mL/hr) to start at 6 am (pm) via pump

___ Intermittent feeding of _____ mL every _____ hrs at _____ mL/hr via pump; Flush feeding tube manually with _____ mL water before and after each feeding

___ Bolus feeding _____ mL (_____cans) every _____ hours; or _____ times/day
Comments (i.e. specific times): _____
_____
Flush feeding tube manually with _____ mL water before and after each feeding via syringe

Estimated length of need (number of months): _____ (1 - 99, 99 = lifetime)

NOTE: Automatic water flush of 50 mL/hr provided during hours that the formula is administered

Additional Options:
___ Additional water flush of _____ mL _____ via feeding tube
X Proform Protein Supplement 30 mL 2 times daily via feeding tube
___ Other _____
_____

Tube Feeding/Parenteral/Oral Nutrition: see separate TPN Order Form or Oral Diet order form

Medical Provider's Signature [signature] **Date/Time** 3/11/19
Nurse's Signature** [signature] **Date/Time** 3/11/19
3/12/19 5/17 DK

*****Nurse to call MBS at (914) 738-9400 and fax MD signed EN order form and resident face sheet (pink sheet in chart) to (718) 310-6202 for delivery of formula*****

WHITE-MEDICAL CHART YELLOW-FOOD & NUTRITION SERVICES PINK-PHARMACY
4-2369A REVISED 6/16

KINGSBROOK
JEWISH MEDICAL CENTER

FRANCISQUE ,JEAN M 71
1256 WUBSHET, BERHANE,
VAS PT#: 11045967 DOB: [redacted]
MR#: 0370519 PH#:
REG DT: 03/13/19 TIME 09:34

Rutland Nursing Home Enteral Nutrition Order Form

Any change in enteral feeding requires a new order form. Please send yellow copy to Food and Nutrition Services Department and pink copy to Pharmacy Department.

Adult Enteral Formulas

___ Jevity 1.2 ___ Jevity 1.5 ___ Osmolite 1.2

___ Glucerna 1.0 ✓ Glucerna 1.2 ___ Promote with Fiber

___ Perative ___ Pivot 1.5 ___ Two Cal HN

___ Nepro ___ Suplena ___ Vital 1.2

___ Vivonex (for milk protein allergy) ___ Other _____

Total formula volume/24 hours:

___ 1000 mL ✓ 1500 mL ___ 2000 mL ___ Other _____

Check one of the following:

✓ Continuous feeding at 85 mL/hr (not to exceed 99 mL/hr) to start at 6 am (pm) via pump

___ Intermittent feeding of _____ mL every _____ hrs at _____ mL/hr via pump;
Flush feeding tube manually with _____ mL water before and after each feeding

___ Bolus feeding _____ mL (_____cans) every _____ hours; or _____ times/day
Comments (i.e. specific times): _____

Flush feeding tube manually with _____ mL water before and after each feeding via syringe

Estimated length of need (number of months): 99 (1 - 99, 99 = lifetime)

NOTE: Automatic water flush of 55 mL/hr provided during hours that the formula is administered

Additional Options:

___ Additional water flush of _____ mL _____ via feeding tube
✓ Proform Protein Supplement 30 mL (2) times daily via feeding tube 3/14/19 11:57A Joseph, LPN
___ Other _____

Tube Feeding/Parenteral/Oral Nutrition: see separate TPN Order Form or Oral Diet order form

Medical Provider's Signature per [illegible] **Date/Time** _____
Nurse's Signature** [illegible] **Date/Time** 3/14/19
Yo Dr Wubshet Mi 11/14/2019
Nurse to call MBS at (914) 738-9400 and fax MD signed EN order form and resident face sheet (pink sheet in chart) to (718) 310-6202 for delivery of formula [illegible] 3/14/19 3-14

WHITE-MEDICAL CHART YELLOW-FOOD & NUTRITION SERVICES PINK-PHARMACY
4-2369A REVISED 6/16

RNH 03/0519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

KINGSBROOK
JEWISH MEDICAL CENTER

Rutland Nursing Home Enteral Nutrition Order Form

Any change in enteral feeding requires a new order form. Please send yellow copy to Food and Nutrition Services Department and pink copy to Pharmacy Department.

Adult Enteral Formulas

___ Jevity 1.2	____ Jevity 1.5	___ Osmolite 1.2
___ Glucerna 1.0	✓ Glucerna 1.2	___ Promote with Fiber
___ Perative	___ Pivot 1.5	___ Two Cal HN
___ Nepro	___ Suplena	___ Vital 1.2

___ Vivonex (for milk protein allergy) ___ Other _____

Total formula volume/24 hours:
___ 1000 mL ✓ 1500 mL ___ 2000 mL ___ Other _____

Check one of the following:
✓ Continuous feeding at 85 mL/hr (not to exceed 99 mL/hr) to start at 6 am (pm) via pump

___ Intermittent feeding of _____ mL every _____ hrs at _____ mL/hr via pump;
Flush feeding tube manually with _____ mL water before and after each feeding

___ Bolus feeding _____ mL (_____cans) every _____ hours; or _____ times/day
Comments (i.e. specific times): _____

Flush feeding tube manually with _____ mL water before and after each feeding via syringe

Estimated length of need (number of months): 99 (1 - 99, 99 = lifetime)

NOTE: Automatic water flush of 55 mL/hr provided during hours that the formula is administered

Additional Options:
___ Additional water flush of _____ mL _____ via feeding tube
✓ Proform Protein Supplement 30 mL 2 times daily via feeding tube
___ Other _____

Tube Feeding/Parenteral/Oral Nutrition: see separate TPN Order Form or Oral Diet order form Boost 1 3

Medical Provider's Signature _____ **Date/Time** _____
Nurse's Signature** Stanley **Date/Time** 4/5/19

TTO from Dr Wubshet to Stanley

Nurse to call MBS at (914) 738-9400 and fax MD signed EN order form and resident face sheet (pink sheet in chart) to (718) 310-6202 for delivery of formula 4/8/19 11R 7A Joseph

WHITE-MEDICAL CHART YELLOW-FOOD & NUTRITION SERVICES PINK-PHARMACY
4-2369A REVISED 6/16

KINGSBROOK JEWISH MEDICAL CENTER
RUTLAND NURSING HOME

RNH 03/05/19 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
[redacted] M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

ADMISSION NOTE ☐ (Check One)
ANNUAL REVIEW NOTE ☐

DATE: 3/8/19

History: Reason for admission to Nursing Home/Medical problems/Past Medical History/ROS: 71 y/o male w/ PMHx of ischemic stroke with hemorrhagic conversion, HTN, T2DM, s/p PEG placement on 2/22/19, ^tinea cruris, was transferred from Kings County Hospital. Due to aphasia, unable to assess review of systems.

Medications: ASA 81 mg (CAD prophylaxis) Metoprolol 100 mg Q12 (HTN), Ranitidine 150 mg BID Levemir 20 units q12 (T2DM), Aspart 18 units Q6 (T2DM), Nystatin (GI prophylaxis) powder BID (groin rash)

Allergies: Unknown PPD Status: Unknown

Surgical History: Unknown

Psychiatric History: Unknown

Social History: Unknown

Current Functional Status: bed bound 2/2 CVA

Hearing: intact Vision: intact

Pertinent Laboratory Data:

Date of last mammogram for females: N/A

Stool for occult blood: Date last tested _____ Result: Positive _____ Negative _____ Not Known

PHYSICAL EXAM:

Vital Signs: Pulse 120 B/P 146/86 Resp. 28 Temp. 97.4 Wt. 144 Ht: 67" O_2 = 98

General Appearance/Mental Status: Pt alert nonverbal, lying in bed comfortably BMI 22.5

Skin/Scars: Left heel SDTI 2.5 cm x 3 cm, 0cm depth, 0/10 pain scale

Pressure ulcers: See above

Lymphatic: No LAD or edema noted.

Head/Neck: NCAT, no JVD, no carotid bruits, trachea midline, (R) ear impacted

Eyes/Ears/Nose: (L) eye PERRL (R) eye did not react, no conjunctival injection o/i (L) ear unable to assess

Mouth/Teeth: Moderate dentition, superior aspect of tongue covered in white plaque, pharynx clear

Form #4 - 1850 Revised 11/01

Lungs: CTAB, No rhonchi, rales, or wheezing. Equal rise + fall of chest wall.

Cardiovascular: Tachycardic, regular rate + rhythm, No murmurs, rubs, gallops

Abdomen: Soft, NTND, PEG intact w/o signs of infection, no erythema

Genitalia: Texas catheter in place draining clear yellow urine

Pelvic:

Rectal/Prostate: Deferred

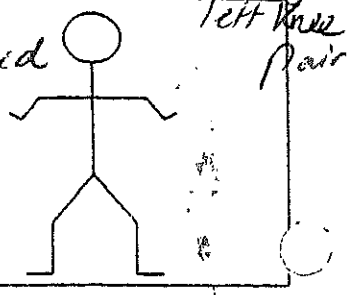
Back:

Extremities: Radial + pedal pulses 2+ b/l and equal, cap refill < 2 sec

Feet: Swollen + tender (L) knee, normal temperature, non-erythematous

Contractures: No contractures

Neurological Exam: B/l UE and LE weakness, difficult to assess + compare sides due to pain

Mental/Cognitive Status: Gait: N/A Cranial Nerves unable to assess Speech: Pt verbalizes "yes" + "no" Swallowing: N/A	Motor: Muscle strength LLE 0/5, RLE 0/5, LUE 3/5, RUE 2/5 Muscle tone: Tremor: None Sensory: sensation to pain intact, unable to assess light/sharp/dull sensation	DTR not assessed PLANTARS  left knee pain

PAIN MANAGEMENT — Pt says "yes" - does not endorse a number

0 NONE 2 4 MODERATE 6 8 10 WORST

FOR LEVEL 2 OR HIGHER CHECK TYPE OF INTERVENTION

☐ MEDICATION ☐ OTHER

Other physical findings:

ASSESSMENT AND PLAN:

Yes	No	(Check appropriate box)	Yes	No	(Check appropriate box)
☑	☐	NG/PEG Tube	☐	☑	Do Not Resusitate (If NO Consider Obtaining DNR)
☐	☑	Picc or CVP line / heplock	☑	☐	Foley / Supra-pubic / Texas Catheter
☑	☐	Pressure Ulcers	☐	☑	Trach
☐	☑	Psychoactive Medications			

71 y/o male w/PMH of CVA, HTN, T2DM - Good candidate for SNF for Rehab.

Ischemic stroke w/ Hemorrhagic Conversion, apraxia and w : ASA 81 mg

1) HTN: Trend BP to determine if controlled. Continue Metoprolol 100 mg q12

2) Type 2 DM: Trend fingersticks due to HgbA1c of 11.0%, determine if controlled. Continue Levemir 20 units q12, Aspart 6 units

3) Tinea cruris: Continue Nystatin powder BID to groin, reassess area periodically for necessity.

Potential for discharge:

5) Knee pain: Xray ordered of Left knee pending

Signature:

KINGSBROOK
JEWISH MEDICAL CENTER

RUTLAND NURSING
DEPARTMENT OF NU

NURSING ADMIS
EVALUATION

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
LTCM/W[illegible] I CATHOLIC TW 1013B
[illegible], B.
ACCNT#: 1643155

DEMOGRAPHIC INFORMATION

Evaluation must be initiated upon admission of resident and complete within 24 hours.

Admission Date: 3/6/19 Time: 8:45 pm Mode of Transportation:
Admitted From: ☐ Home ☐ Hospitalized: _____ (specify) ☑ Other Facility Kings County Hospital (specify)
Reason for Admission: ☑ STR ☐ LT ☐ Other: _____
Was family / designated representative present at time of admission? ☐ Yes ☐ No
Accompanied by: 2 Ambulance attendants & family members Relationship: Spouse & daughter
Vital Signs: T: 98 P: 113 R: 18 B/P: 134/68 WT: 144 HT: 5ft. 7"
Allergies: Medication(s): NKA Food: ☑ NKA
Advanced Directives: ☐ None ☐ DNR ☐ Living Will ☐ DNI ☐ HCP
(Information requested: ☐ Yes, if yes refer to Social Services)
Religion / Spiritual Practice: _____ Cultural Practice: _____
Family / Living Structure: One bedroom apartment Resides with: Alone
Admitting Diagnosis: Stroke with hemorrhagic conversion, PEG placed 2/22/19
Past Medical History: HTN, DM
Current Medications: ASA, Metoprolol Indications: Hx HTN Current Medications: Insulin Indications: DM

CUSTOMARY ROUTINES

Sleeping:
Usual Bed Time 11:00 AM/PM
Normal Wake Time 6-7:00 AM/PM
Nap Time Sleeps in/out all day AM/PM
Unable to Assess _____

Smokes: ☑ No ☐ Yes Cigarettes / day _____
Uses Alcohol ☑ No ☐ Yes Type _____ Frequency _____
Use of Illicit drugs ☑ No ☐ Yes Type _____ Frequency _____
Other _____

HEALTH EVALUATION

VISION

☐ Impaired ☐ R ☐ L
☐ Prosthesis ☐ R ☐ L
☐ Glasses
☐ Contact Lenses ☐ R ☐ L
☐ Special Lenses
☑ No Impairment

Comments: _____

HEARING

☐ Impaired ☐ R ☐ L
☐ Deaf
☐ Hearing Aid ☐ R ☐ L
Type of Aid _____
☐ Refuses to Wear Hearing Aid
☐ Lip Read
☑ No Impairment

Comments: _____

APPEARANCE

☑ Clean, Neat & Well Groomed
☐ Grooming needed
☐ Body Odor
☐ Soiled Clothing
☐ Shaved ☐ Yes ☐ No

Comments: _____

MENTAL STATUS

☐ Oriented to:
☐ Time ☐ Place ☑ Person
☐ Know name.
☐ Know age.
☐ Remember last meal.
☐ Repeat sequence of number.

Comments: _____

CONSCIOUSNESS

☑ Alert
☐ Lethargic
☐ Non-responsive
☐ Other

Comments: _____

COMMUNICATION ABILITY

☑ Language of Choice English/Creole
☐ Speaks well
☐ Comprehends conversation and writing.
☐ Cannot verbalize.
☐ Able to express self.
☐ Slow to respond
☐ Use sign language
☐ Interpreter required

Comments: _____

FORM 4-1329 5/08

HEALTH EVALUATION CONT'D

Foot

- ☑ Long Nails
- ☐ Foot Drop
- ☐ Foot Pain/Discomfort
- ☐ Corn or Callous
- ☐ Pedal Pulse Present
- ☐ Stasis Ulcer
- ☐ No Impairment
- ☐ Discoloration (Specify if Present)_____
- ☐ Pressure Ulcer

(Comment): _____

Oral

- ☑ Mucosa Intact
- ☐ Presence of Lesion
- ☐ Coated Tongue
- ☐ Halitosis
- ☐ Inflamed Gums
- ☑ Natural Teeth
- ☐ Missing Teeth
- ☐ Carious Teeth
- ☐ No Teeth
- ☐ No Dentures
- ☐ Wears Dentures:
- ☐ Full U_____ L_____
- ☐ Partial U_____ L_____
- ☐ Partial Bridge: U_____ L_____

Observable Evidence of Abuse or Neglect

SIGNS OF:

- ☐ Physical Assault - Bilateral Bruises
- ☐ Psychological Abuse - Cringing
- ☐ Rape or Other Sexual Molestation
- ☐ General Bruises
- ☑ None of the Above
- ☐ If, yes, Refer to SW or DNS

REVIEW OF SYSTEMS

MUSCULOSKELETAL

☐ Stiffness of Joints / Swelling ☐ Weakness / Paresis
☐ Unable to Move ☐ Right_____ Left_____ ☐ Arthritis
☐ Amputation: Right_____ Left_____
☐ Limited Range of Motion ☑ Yes ☐ No
☐ No Impairment ☐ Restorative Care Referral: PT_____ OT_____

NEURO/CEREBRAL FUNCTION
Alteration in thought processes

☐ Decreased Attention Span ☐ Altered Perception Tremors
☐ Family Report Change in Behavior ☑ Impaired Memory ☐ Seizures
Pupils: ☑ Equal ☐ Unequal ☐ Impaired Judgement ☐ Paresthesia
Hand Grasp: ☐ Equal ☑ Unequal ☐ Strong ☑ Weak

Alterations in communications

☐ Ataxia ☐ Confusion ☐ Wanders ☐ Comatose ☐ Combative ☐ Restlessness
☐ Paralysis ☐ Headaches ☐ Anxiety ☐ Agitation ☐ Speech Difficulty ☐ ST_____

RESPIRATORY
Ineffective airway clearance.
Ineffective breathing patterns.
Impaired gas exchange.

Respiration:
☑ Regular ☐ Irregular ☐ Ventilator ☐ Tracheostomy ☐ Suctioning
Breath Sounds
☑ Clear ☐ Crackles ☐ Wheezing ☐ Rhonchi ☐ Diminished
☐ Dyspnea ☐ Cough ☐ Sputum ☐ pleuritic Pain ☐ Hoarseness
☐ History of COPD ☐ Shortness of breath ☐ Upper Respiratory Infection
☐ Uses O2 ____ Nasal Cannula ____ Mask ____L / Min

CIRCULATORY
Decreased Cardiac output.
Alteration in peripheral tissue perfusion.
Alteration in fluid volume.

Heart Sounds: ☑ Regular ☐ Irregular
☐ Palpitations ☐ Vertigo ☐ Syncope ☐ Known Murmur
History of: ☐ Hypertension ☐ Leg Cramps ☐ Edema
☐ Numbness ☐ Chest Pains ☐ Varicosities
Peripheral Pulses: ☐ Present ☐ Absent ☐ Weak ☐ Strong
☐ Pacemaker:_____Rate _____Insertion Date_____Serial #_____
☐ Shunt ☐ Palpable Thrill

IMMUNE FUNCTION
Potential for Infection

☐ Chronic Disease ☐ Radiation ☐ Steroids ☐ Chemotherapy ☐ Chills
☐ Increased Temperature ☐ Decreased Temperature ☐ Temperature within Normal Range
☐ Invasive Device Hickman (Broviac) Catheter

Alteration in Body temperature.

☐ Renal Failure ☐ Hepatic Disease ☐ Lymphatic

NUTRITION
Alterations in Nutrition

☑ Diet PEG ☐ Food Preference_____
Appetite:
☐ Poor/ ☐ Fair/ ☐ Good ☐ Difficulty Chewing
☐ Nausea / Vomiting ☐ Recent Weight Loss / Gain ☐ Tube Feeding/Parenteral Fluids
☐ Ability to Swallow ☐ Difficulty Swallow ☐ Dehydration
Skin Type:
☐ Firm ☐ Loose

GASTROINTESTINAL

Alterations in bowel elimination.

☐ Continent Incontinent: ☑ Bladder ☑ Bowel
☐ Constipation ☐ Diarrhea ☐ Date of Last BM Today
☐ Hemorrhoids ☐ Flatulence ☐ Abdominal Pain ☐ Cramps
☐ Abdomen ☑ Soft ☐ Rigid ☐ Tender ☐ Distended Girth if needed_____
Bowel Sounds: ☐ Present ☐ Absent
Laxative Use: ☐ Yes ☐ No
Ostomy: ☐ Ileostomy ☐ Colostomy

GENITO - URINARY

Alterations in urinary elimination.

☐ Continent ☑ Incontinent ☐ Frequency ☐ Urgency ☐ Pain
☐ Polyuria ☐ Dysuria ☐ Hematuria ☐ Nocturia ☐ Retention
☐ Dribbling
Ostomy: ☐ Ileoconduit ☐ Nephrotomy
Dialysis: ☐ Hemodialysis ☐ Peritoneal
Catheter: ☐ Foley ☐ Suprapubic ☐ Peritoneal ☐ Texas
Urine: Color Clear Odor_____ Volume_____

REVIEW OF SYSTEMS

GENITO - URINARY: FEMALE Vaginal Discharge___ Itching___ Lesions___

Date LMP___ Date of Last Pap Smear___ Date Last Mammogram___

MALE Scrotal Swelling no Lesions no Discharge no Other___

INTEGUMENTARY

Alteration in skin and tissue integrity

Color: ☐ Pale ☐ Ashen ☐ Mottled ☐ Normal Color ☐ Cyanotic ☐ Jaundiced ☐ Flushed

Temperature: ☐ Hot ☐ Cool ☐ Cold ☐ Warm ☐ Moist ☐ Disphoretic ☐ Clammy

Edema: ☐ General ☐ Local ☐ None Odor: ☐ Foul ☐ Mild ☐ None

Exudate: ☐ Serosangrinous ☐ Purulent ☐ None

☐ Fragile Skin ☐ Dry

Decubitus Present on Admission ☐ No ☐ Yes

If yes, describe below:

Potential for Impaired Skin Integrity ☐ No ☐ Yes

(Complete Norton Scale)

STAGE I

Nonblanchable erythma of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.

STAGE II

Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.

STAGE III

Full thickness skin loss involving damage of substaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

STAGE IV

Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, join capsule). Undermining and sinus tracts also may be Stage IV pressure ulcers. Eschar is Stage (IV).

DIRECTIONS:

SKIN RISK EVALUATION: Scoring Scale must be circled in each category and totaled.

PRESSURE ULCER RISK ASSESSMENT (BRADEN SCORE)

Sensory Perception	Moisture	Activity	Mobility	Nutrition	Friction & Shear
Completely limited 1	Constantly moist 1	Bedfast 1	Completely immobile 1	Very poor 1	Problem 1
Very limited 2	Very moist 2	Chairfast (2)	Very limited 2	Inadequate (2)	Potential problem 2
Slightly limited (3)	Occasionally moist (3)	Walks occasionally 3	Slightly limited (3)	Adequate 3	No apparent problem (3)
No Impairment 4	Rarely moist 4	Walks frequently 4	No limitations 4	Excellent 4	

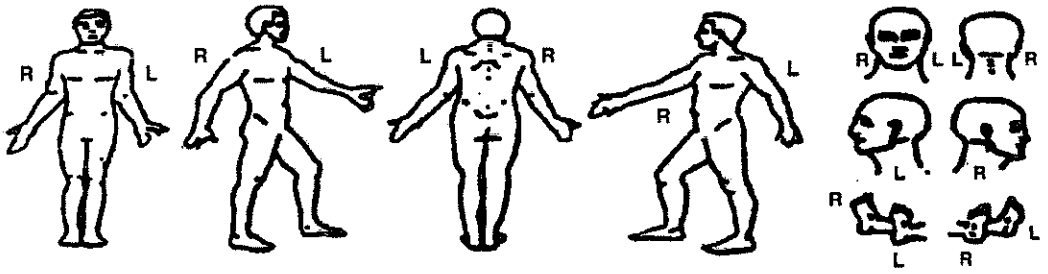
RESIDENTS WHO SCORE 18 OR LESS ARE AT RISK FOR PRESSURE ULCERS. INITIATE PRESSURE ULCER PREVENTION PROTOCOL AND REFER TO NUTRITION SERVICE.

Indicate skin findings by placing alphabetical letter on the diagram. Indicate size in cm (L x W x D). Indicate Stage in numerals (I, II, III, IV)

A. Abrasions
B. Burns (second or third degree)
C. Open lesions other than ulcer rashes, cuts (e.g. cancer lesions)
D. Skin desensitized to pain or pressure
E. Surgical wounds/sutures
F. Ecchymosis
G. Scars
H. Skin tears or cuts or laceration
I. Pressure Ulcers
J. Rashes (e.g. interrigo, eczema, drug rash, heat rash, herpes zoster)
K. Vascular Ulcers
L. Reddened areas (Do not include Stage I Pressure Ulcers)

Indicate position of Eschar, Tunneling, Undermining by the Clocks

Pressure Ulcers Stage___ (L___ W___ D___)	Eschar	Tunnel	Undermine
1			
2			
3			
4			
5			

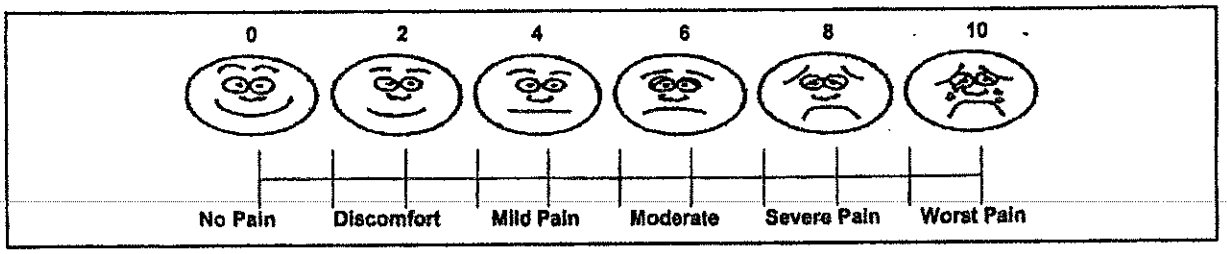


1	Information is obtained from: ☑ patient ☐ S/O ☐ caregiver ☐ transfer sheet ☐ ED Form ☐ Other
2	Does the patient have or exhibit signs of pain? ☐ Yes ☑ No **(If *YES, complete* form. If *NO,* go to question #16):**
3	Manner of **expressing** pain: ☐ verbal ☑ non-verbal
4	**Select one of the following Pain Intensity Measurement Tools, determine score and complete section #5.**

• **FLACC Behavioral Pain Scale – (F) Faces, (L) Legs, (A) Activity, (C) Cry, (C) Consolability - is for patients who are: ◆ non-verbal ◆ under 3 years old ◆ mentally challenged or ◆ have a decreased LOC.** *Measure* each of the five FLACC Scale categories scoring from 0 - 2, by *circling* the FLACC score that correlates with the patient's demonstrated behavior and *add* the total score (which ranges from 0 -10).

Categories	Score 0		Score 1		Score 2	
FACE	No particular expression or smile	0	Occasional grimace or frown, withdrawn, disinterested	1	Frequent to constant frown, quivering chin, clenched jaw	2
LEGS	Normal position or relaxed	0	Uneasy, restless, tense	1	Kicking or legs drawn up	2
ACTIVITY	Lying quietly, normal position, moves easily	0	Squirming, shifting back and forth, tense	1	Arched, rigid or jerking	2
CRY	No cry (awake or asleep)	0	Moans or whimpers; occasional complaint	1	Crying steadily, screams or sobs, frequent complaints	2
CONSOLABILITY	Content, relaxed	0	Reassured by occasional touching, hugging or being talked to distractible	1	Difficult to console or comfort	2

• **Faces/Numeral Pain Measurement Tool – Faces Measurement Tool for Pts.: ◆ 3 to 10 years ◆ elderly or ◆ with a language barrier. Use the Numeric Measurement Tool for patients > 10 years.**



5	**A. Intensity of pain on a scale of 0-10: Present** _____ **B. Patient's acceptable pain level or goal** _____
6	**Type** of pain ☐ Acute ☐ Chronic
7	**Onset** of pain: Approximate Date_____ Time____:____ ☐ AM ☐ PM
8	**Duration** of pain (How long does the pain last?): ☐ minutes ☐ hours ☐ never goes away
9	When does the pain most **frequently** occur? ☐ Day ☐ Evening ☐ Night
10	**Location** of Pain: ☐ Head/Neck ☐ Abdomen ☐ Chest ☐ RA ☐ RL ☐ LA ☐ LL ☐ Back ☐ Incisional ☐ Perineal ☐ Other (Specify) –
11	Pain **radiates**: ☐ No ☐ Yes (if yes, to where?):_____
12	**Characteristic** of pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache ☐ Pulling ☐ Throbbing ☐ Pressure ☐ Cramping ☐ Spasm ☐ Other (Specify) –
13	What **relieves** the pain? ☐ Resting ☐ Swimming ☐ Massage ☐ Aroma Therapy ☐ Music ☐ Ice Pack ☐ Heat Pack ☐ Position Change ☐ Cultural Practice* ☐ Religious Practice* ☐ Medication* ☐ OTC* ☐ Herbal Supplements* ☐ Other* (*) Specify –
14	What **causes** or **increases** the pain? ☐ Lifting ☐ Sitting ☐ Walking ☐ Bending ☐ Pulling ☐ Pushing ☐ When resting ☐ After exercise ☐ Standing ☐ Other (Specify) –
15	What are the **effects** of pain? (check all that apply) ☐ Symptoms accompany pain (ie: nausea) ☐ Poor appetite ☐ Sleeplessness or **sleep interruption** ☐ Decreased or limited function ☐ Irritability ☐ Anger ☐ Withdrawal ☐ Loss of concentration ☐ Issues with personal relationships ☐ Other (Specify) –
16	Pain Education **initiated:** ☐ Patient ☑ Family ☐ S/O ☐ Caregiver ☐ unable to communicate with patient
17	**What pain education was initiated:** ☑ Relaxation Measures ☐ Splinting ☐ Medication ☐ Position change ☐ Breathing exercises ☐ Pain Scale explained ☐ Other (Specify) –

Date 3/6/19 **Time** 9:15 ☐ **AM** ☑ **PM** **Signature** [signature] **NURSE**

FALLS RISK FACTOR			SCORE	ACTUAL SCORE
Age 65 years or older		2	2	2
History of falls (6 months to 1 year)	*	15		
Unsteady Gait / Balance Problem	*	15	15	15
Vertigo		3		
Osteoporosis		2		
Seizure Disorders		3		
Weakness / Multiple Myeloma	*	2	2	
Degenerative Joint Disease		2		2
Paresis /Paralysis	*	3		
Hearing Impairment		2		
Sight Impairment		3		
Impaired Mental Status/Confused / Disoriented		15	15	15
Drugs that have a diuretic effect / Incontinence / Nocturia		3		
Drugs that suppress thought processes and create a hypotensive effect i.e.: narcotics, sedatives, hypnotics, tranquilizers, antidepressants, antihypertensives.			6 (1 med) 7 (2 meds) 8 (3 meds) 9 (4 meds)	1
Drugs that increase GI motility i.e.: laxatives		3		
Amputee Single above knee	*	7		
Single below knee	*	4		
Double above knee	*	9		
Double below knee	*	7		
Assistive Device Wheelchair		4		4
Crutches		4		
Cane		4		
Walker		4		
Other		4		
Impaired ADL		4		4
		Total Score		
		Write sum of scores in the boxes		43

Implement Fall Prevention Protocol for a score greater than 4
Responses with * require discussion for Rehab referral with MD documented in the PROGRESS notes.

ORIENTATION TO FACILITY

Facility Regulations	☐	Call Light	☑	Activities	☐	Personal Property:	
Resident Bank	☐	Day Room	☐	Telephone	☐	Inventory Checklist	
Roommate	☑	Bathroom	☐	ID Bands	☐	Report to Staff Any Losses	
Smoking Rules	☐	Safety Information Given	☐	Meal Time	☐	Unable to Orient (reason):	
Self Medication	☐	Privacy of Other Resident	☐	Visiting Hours	☐		
Introduction to Staff	☑	Storage/Locked Closet/Keys	☐	Lighting	☐		
Valuables	☐	Personal Item List	☐	Over Bed Table	☐		
Unit Routines	☐	TV Bed Controls	☑				

FUNCTIONAL EVALUATION: SELF DEFICIT

	Eating	Ambulation	Transfer	Dressing	Toileting	Personal Hygiene	Bed Mobility	Bath
Independent								
Supervision								
Limited Assistance								
Extensive Assistance	/							
Total Dependence								
1 Person Assist		/	/	✓	✓	✓	✓	✓
2 Person Assist								

BATH PREFERENCES: ☐ AM ☐ PM ☐ TUB ☐ SHOWER
☑ Chair fast ☐ Bedfast ☐ Cannot Ambulate ☐ Stand Only
DEVICES: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Handrails ☐ Hydraulic Lift
EQUIPMENT: ☐ Bedpan ☐ Urinal ☐ Commode ☐ Toilet ☐ Incontinent Brief/Pad
Resident/Family Education Needs: Knowledge deficit (complete Interdisciplinary Patient/Family Education Referral Form).
Signature of the nurses who have participated in completing this evaluation:

Nurse _____ Date 3/6/19

Nurse Manager/Supervisor _____ Date 3/6/19

KINGSBROOK JEWISH MEDICAL CENTER
RUTLAND NURSING HOME

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

SCHEDULED PHYSICIAN VISIT
PROGRESS NOTE

DATE: April 4, 2019

SUMMARY OF PROGRESS/CHANGES SINCE LAST REVIEW:

Pt is a 71 yr old AA male w/ a pmhx of Ischemic stroke, w/ hemorrhagic conversion, HTN, T2DM presenting today for his monthly f/u, w/ no acute events, pt denies any changes in vision, headache, n/v/f/c/d, vertigo or syncopal related events; denies fevers, chill.

PHYSICAL EXAM: Weight this month: 141.6 **lbs Weight last month: :** 141.3 **lbs**

Desired weight change: N/A **Yes** N/A **No**

Weight this month = 141.3 **Lbs** **T=** 97.4 **°F** **P=** 72 **/mt**

Weight last month = 141.6 **Lbs** **R=** 14 **/mt** **BP=**134/88 **mmHg**

General- Pt is Alert & Oriented x2, well groomed, no abnormal smells, good hygiene

HEENT- Head is NCAT, eyes are symmetrical b/l, no discharge, trauma, bruising, eyes are symmetrical, PERRLA,

Pulm - clear lung sounds bilaterally, no crackles, wheezing, rubs, rhonchi heard upon auscultation

Cardio - S1, S2, no S3, S4, rubs, murmurs, gallops, bruits or thrills appreciated

Abdomen- normoactive bowel sounds, nondistended, non-distended.

MSK - good muscle strength 5/5 in upper extremities bilateral, unable to roll to sacral or ambulation for the lower extremities.

Vascular- carotid, radial, popliteal, posterior tibial, dorsalis pedis 2+ bilat & tapping.

Neurovascular - pt. is A&O x2, unable to answer 3rd questions adequately, pt. seems a little disoriented.

PERTINENT LABORATORY RESULTS:

CONSULTATIONS/RECOMMENDATIONS:

Follow up w/ neurology

ASSESSMENTS AND PLAN:

YES	NO	
		1. FOLEY / SUPRA-PUBIC / TEXAS CATHETER
	✓	2. TRACH
	✓	3. NG / PEG a. CONDITION OF THE SIGHT b. Continued NEED
	✓	4. PICC OR o CVP LINE / HEPLOCK a. CONDITION OF THE SIGHT b. Continued NEED
	✓	5. CLINICALLY SIGNIFICANT WEIGHT CHANGE? IF YES, INDICATE PLAN & ASSESSMENT BELOW.
		6. PROBLEM LIST REVIEWED AND UPDATED?
		7. PRESCRIBED MEDICATIONS REVIEWED TO ADDRESS THE ISSUE OF UNNECESSARY DRUG USE?
	✓	8. PRESSURE ULCERS? IF YES ABOVE: CHECK ALBUMIN, PRE-ALBUMIN AND PROTEIN LEVELS (ORDER IF NEEDED)
		9. PHYSICAL DEVICES SCREENING TOOL FORM REVIEWED:
	✓	10. PODIATRIC FOLLOW/UP INDICATED?
✓		11. RESIDENT ON REHABILITATION PROGRAM? ❑ PT ❑ OT ❑ ST
	✓	12. PSYCHOACTIVE MEDICATIONS ARE USED IF YES ABOVE: SIDE EFFECTS NOTED? CONTINUED NEED FOR MEDICATION? DOSAGE REDUCTION APPROPRIATE, (IF "YES" COMMENT BELOW)
	✓	13. BEHAVIOR PROBLEMS
✓		14. DX OF DIABETES MELLITUS
	✓	IF YES ABOVE: IS THERE AN OPTHAMOLOGY CONSULT WITHIN 1 YEAR? IS THERE A BUN/CR WITHIN 6 MONTHS? IS THERE A U/A WITH PROTEIN MICROALBUMIN WITHIN 1 YEAR?
		15. NEED TO REQUEST PSYCHIATRIC CONSULTATION/FOLLOW-UP
	✓	16. DO NOT RESUCITATE (IF NO CONSIDER OBTAINING DNR)
	✓	17. DO NOT INTUBATE (IF NO CONSIDER OBTAINING DNI)

PAIN MANAGEMENT

(0)	2	4	6	8	10
NONE (circled)		MODERATE			WORST

FOR LEVEL 2 OR HIGHER
CHECK TYPE OF INTERVENTION

❑ MEDICATION ❑ OTHER

ASSESSMENTS AND PLAN – CONTINUED:

Pt. is a 71 yr. old AA male w/ pmhx. of HTN, Type 2 DM, Left MCA Ischemic Stroke, presenting w/ no acute events, presenting to be clinically stable. Pt. is up to date with vaccinations, continue to maintain medications and maintain therapies as well as promoting ambulation and independence to maintain/possibly improve ADL's as much as possible, considering pts. pmhx. of the Left MCA, follow up w/ any changes in speech or mentation w/ neurology.

SIGNATURE: [illegible]

Form #4 - 1827

KINGSBROOK JEWISH MEDICAL CENTER
DAVID MINKIN REHABILITATION INSTITU'

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
0 M CATHOLIC TW 1013B x/Age
LTCM/WUBSHET, B. /Ser.

ACCNT#: 1643155

PROGRESS NOTES

DATE	TIME	SERVICE	NOTES
3/6/19	9:15p	NSg	71 y/o Male admitted to Unit from Kings County hospital at 8:45pm via stretcher accompanied by 2 Ambulance attendants & family members. DX: Stroke with hemorrhagic Conversion. PEG placed 2/22/19 Hx of HTN, DM. VS T98 P 113 R18 BP 131/88 Weight: 144 lbs O2Sat 99% BS 155mg/dL. Alert, Oriented to person. Responds Intermittently to Verbal stimuli. PERRLA. No redness/discharge noted from eyes. Hearing intact. No visual impairment. No nasal discharge/congestion. Mucous membrane moist & pink. Has some of his natural teeth. No abnormalities of head. Negative JVD. Respirations even, unlabored, breath sounds clear to auscultation throughout all lung fields. Abdomen round, nondistended. PEG tube Bowel Sounds in all 4 Quadrants. PEG in place. Hand grip weak bilaterally, fingernail beds & Capillary refill < 2 seconds. Foley Catheter in place draining Clear Colored Urine. Skin warm, dry & intact. No skin breakdown noted. Feet warm & dry & thick toenails bilaterally. Pedal pulse Equal bilaterally. Incontinent B+B. Require assist x1 for ADL's & personal hygiene. Denied pain on admission. Safety measures in place. Bed kept in lowest position, call bell

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

FORM 4-1508 REV. 6/81 HS

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
C M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

KINGSBROOK JEWISH MEDICAL CENT[ER]
DAVID MINKIN REHABILITATION INSTI[TUTE]

PROGRESS NOTES

DATE	TIME	SERVICE	NOTES
			placed within reach & instructed to call for any needs or to request assistance before attempting to get up. Will continue to monitor. Orders received from Dr Wubshet. [signature]
3/19	5:40 AM	NSG	Alert and responsive, no S/S of distress, S/P admission day #1, Skin intact, G-T feeding in progress Glucerna 1.2 at 55ml/HR, tolerating well, peg site intact, no drainage or redness noted, incontinent of bowel and bladder, one person for ADL'S and two for transfers Texas catheter in place with amber urine draining, no signs of pain, Safety maintained condition stable. B/P 136/83, P105, R20, T98.1. Joseph, LPN
3/7/19	3PM	NSG	Resident is alert and responsive post ~~in house~~ admission to unit adjusting well. GT intact and patent, texas cath intact draining amber colored urine. Resident requires total assistance no c/o voiced of pain or discomfort will continue to monitor. TPR 98-92-19 BP 124/68 [signature]

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RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

KINGSBROOK JEWISH MEDICAL CENTER
DAVID MINKIN REHABILITATION INSTITUTE

PROGRESS NOTES

DATE	TIME	SERVICE	NOTES
3/7/19	2:15pm	Nsg	Resident was observed c lt heel DTI measures 2½cm x 3cm dark skin mushy. MD made aware. wife/daughter also made aware. See CCP.
			[signature]
3/7/19	4:00pm	EKG	
			EKG EKG
			Done by D.F.
3/7/19	6pm	SW	48 hour initial Care plan w/e Resident is a 71 year old male admitted to RNH from Kings County Hospital. Resident was seen bedside appeared sleeping did not respond to his name. Resident's daughter fabiola (917) 535-3262 visited today. was able to provide some information. Resident was totally independent prior to hospitalization on 2/7/19. His diagnosis include Nontraumatic intracerebral hemorrhage hypertension type 2 diabetes mellitus

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

FORM 4-1506 REV. 6/81 HS

KINGSBROOK JEWISH MEDICAL CENTI
DAVID MINKIN REHABILITATION INSTIT

PROGRESS NOTES

KNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

e
ber
Sex/Age
or/Ser.

DATE	TIME	SERVICE	NOTES
3/7/19	9:6	SW	Resident's daughter was made aware of upcoming care plan/ Discharge planning meeting and family is encouraged to attend. Family was educated on personal belongings. Resident lives with spouse on 2nd floor elevator building with maybe 1 or 2 steps in front. As per daughter the is short term and resident to return home with services if needed. Orientation will be provided to facilitate adjustment to unit and facility service. —Stanley MSW
3/7/19	10	NSG	Resident is alert and responsive. Post New Admission. General Condition Stable. GT Tube intact + patent. Feeds tolerated well. Texas Cath in place draining amber urine. DTI on LT heel off load LT heel on pillow as per MD ordered. PM Care rendered. Resident ambulated well to Unit. Safety maintained. V/S. 98-98- 19-133/75. Monitoring Continues. —Stanley JR

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
KINGSBROOK JEWISH MEDICAL CENTER M CATHOLIC TW 1013B
DAVID MINKIN REHABILITATION INSTITUT LTCM/WUBSHE.., B. Age
PROGRESS NOTES ACCNT#: 1643155 Ser.

DATE	TIME	SERVICE	NOTES
3/8/19	6 AM	N.y.	Resident is alert and Responsive to all stimuli
			S/P Admission day #2, adjusting to environment
			in room, Stable with No Pain no acute distress.
			Safety maintained. B/P 150/89, P 100, T 98.8 R 17 —
			[illegible] LPN.
3/8/19	10:00am	SLP	Speech Language Pathology. Speech/Swallow screen complete
			Pt is a 51 y.o. M admitted to RNH from KCH on 3/6/19 with
			the diagnosis of hemorrhagic stroke, PEG placement 2/22/19 as
			per hospital (KCH) SLP. PMHx includes HTN, DM. This date, Pt
			seen bedside with HOB elevated. AKA & responsive. Pt is
			non-verbal, however able to respond to some yes/no questions via
			eye blink. With regards to swallowing, Pt is currently receiving
			PEG/TF, however, hospital SLP recommended puree solids &
			thin liquids diet as tolerated. Full speech-language/swallow
			evaluation recommended to assess overall communicative
			skills, candidacy for PO intake as well as overall candidacy
			for skilled services. Pt left & distress. Yuliya [illegible]
3/8/19	2pm	NSG	Resident is alert and responsive. Post
			new admission to unit, adjusting well.
			Resident requires 1 person for all ADL activities
			G-T intact and patent feeding tolerated well.
			Foley Cath intact draining amber
			Colored urine out put this day 475ml
			will continue to monitor. TPR 97.9-91-18
			BP 139/77 [illegible]

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

FORM 4-1508 REV. 6/81 HS

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
CM/WUBSHET, B.

KINGSBROOK JEWISH MEDICAL CENTER
DAVID MINKIN REHABILITATION INSTITUTE

PROGRESS NOTES

ACCNT#: 1643155

DATE	TIME	SERVICE	NOTES
3/8/19	1p	NSG	Resident alert and responsive to all stimuli. Command Commands Stable S/P admission day 2/3. OT feeding in progress and patent, Texas Cath in place draining amber urine. Adjacent unit to unit. Safety maintained, Fall Care rendered. V/S. 98.4 - 92 - 19 - 132/75 — Shelly
3/9/19		NSG	Day #3 post admission, alert, verbally responsive, no signs of pain, OT feeding continues, Texas catheter in place with amber urine draining, Safety maintained. B/P 146/91 P104, R18 T98.6. Brigid, RN
3/9/19	2:15p	NSG.	Resident's general condition is unchanged, Vs's day #3 s/p admission to unit, adjusted well to unit, no s/s of pain/discomfort, safety maintained T97. P90 R-17 125/76. — Brigid RN
3/11/19	11:00a	SLP	Speech-Language Pathology Speech/swallow evaluation completed. Pt is a 71 y.o. M known to this service from previous screen completed on 3/8/19, which recommended a full speech-language swallow evaluation to determine Pts oral communicative skills, oropharyngeal swallow function, candidacy for PO intake & overall candidacy for skilled services. This date, Pt. seen bedside with NSG present. Awake, alert & responsive to stimuli. Pt presents with moderate oropharyngeal dysphagia & severe mixed expressive/receptive aphasia. Pt will benefit from skilled services to improve

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY. →

FRANCISQUE ,JEAN M 71
1256 WUBSHET, BERHANE,
VAS PT#: 11045967 DOB:
MR#: 0370519 PH#:
REG DT: 03/13/19 TIME 09:34 Age
Doctor/Ser.

KINGSBROOK JEWISH MEDICAL CENTER
DAVID MINKIN REHABILITATION INSTITUTE

PROGRESS NOTES

DATE	TIME	SERVICE	NOTES
3/11/19	cont'd	SLP	functional communication skills & oropharyngeal swallow func for PO intake. Rx: 1) continue GT feeds as primary means of nutrition/hydration with maintenance of aspiration precautions; 2) initiate skilled speech-language & dysphagia services; 3) discussed w/ & RN; 4) Pt left s̄ distress. Please refer to complete report for details. ——— Yuliya [illegible], MS CF-SLP
3/11/18			Medical Attending F/u
	1:45pm		Resident seen and Lab reports
			reviewed and resident [illegible]
			physical exam is unchanged from
			last week. Pt has tender swelling at (L) knee
			Lab reports: Labs & X-rays at transferring hospital Dr Mudi [illegible]
			[illegible] 131 / 92 / 23 (253 ; 4.2 / 27 / 0.8
			Alb - 2.7
			ALT/AST (-82/34) LDL - 76
			HbA1c - 11.0
			25-hydroxy vit D - 15.49
			WBC 4.5 12.9 / 39 190K
			Quantiferon TB Pend
			A/P
			Anemia
			Vit D deficiency
			Poorly controlled DM, (L) knee OA
			P) - will get Anemia profile
			Start Ergocalciferol, & Levemir

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

FORM 4-1508 REV. 6/81 HS

Berhane Wubshet

KINGSBROOK JEWISH MEDICAL CENTER
DAVID MINKIN REHABILITATION INSTITUTE

FRANCISQUE ,JEAN M 71
1256 WUBSHET, BERHANE.
VAS PT#: 11045967 DOB:
MR#: 0370519 PH#:
REG DT: 03/13/19
TIME 09:34
Doctor/Ser.

PROGRESS NOTES

DATE	TIME	SERVICE	NOTES
3/12/19	9Am	NSG	Resident left unit to xray dept via stretcher accompanied by transporter on duty resident feeding held until returned from xray dept —— [illegible]
			Returned xray Dept xray done.
			X-RAY Chest Date: 3/12/19 Time: 9:55am Tech: [illegible]
			Was seen by therapists and O.T. —— [illegible]
3/19/19	3pm	SW	Social work note : Met with resident's wife today all forms explained and signed - [illegible] LMSW
3/22/19			Medical Attd D/O note
			Asked to see resident by family
			c/o: (L) knee pain
			Pt has h/o OA
			X-ray report from KCMC reveals Arthrosis / OA
			Imp/ — (L) knee OA

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

KINGSBROOK JEWISH MEDICAL CENTER
DAVID MINKIN REHABILITATION INSTITUTE

FRANCISQUE ,JEAN M 71
1256 WUBSHET, BERHANE,
VAS PT#: 11045967 DOB:
MR#: 0370519 PH#:
REG DT: 03/13/19 TIME 09:34

PROGRESS NOTES

DATE	TIME	SERVICE	NOTES
Cont'd			
3/12/19			[illegible] Tylenol p.o. Voltaren 1% topical [illegible] bid. D/c PT/OT [illegible]
3/13/19	3PM	NSG	Resident alert and responsive to all [illegible]. Leaving unit via wheel chair accompanied by transporter to go to vascular. General condition stable — [signature]
	3:23p	VAS	Vascular Laboratory 3-13-19 Venous duplex LE Bilateral. Date Examination. See preliminary report in Radiology section of chart. Official report to follow. [signature]
3/13/19	3:50pm	[illegible]	Resident returned from vascular lab via W/C accompanied by messenger. ø s/s of any discomfort noted. Condition is stable [signature]
3/21/19	11am	SW	Social work/Care plan meeting. Team met today with the resident's family (wife and 2 daughters). Resident is alert verbally responsive however not able to follow commands due to cognitive deficit. Nursing reports compliance with his medications and he requires total care. Resident is on [illegible]

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

FORM 4-1508 REV. 6/81 HS

M 71

KINGSBROOK JEWISH MEDICAL CE
DAVID MINKIN REHABILITATION INS

FRANCISQUE ,JEAN
1256 WUBSHET, BERHANE,
VAS PT#: 11045967 DOB: (
MR#: 0370519 PH#:
REG DT: 03/13/19

TIME 09:34

Name
Number
Loc/Sex/Age
Doctor/Ser.

PROGRESS NOTES

DATE	TIME	SERVICE	NOTES
3/19/19			Medical Attending note
			Lab reports and imaging studies
	4:15P		reviewed
			3/6/19 FBS - 253 Bun/Cr - 23/0.8 Alb - 2.7
			Quantiferon TB - (-) Na - 131
			CXR - Negative HbA1c (11.0)
			U/A - 15.4 g CBC - 3.9 12.6 182 K
			A/P TSH - NL 35
			Hyponatremia LE Venous duplex - Ø
			hyperglycemic
			Hypoalbuminemia
			(+) PPD
			P/ - will start INH + B6
			[illegible]
			Bro [illegible]
3/21/19	10:15	SW	Social work / care plan: Team met today with the resident's family (wife and 2 daughters). Resident is verbally responsive, alert, however not able to follow commands and answer questions due to cognitive deficits. Nursing reports compliance with medication and he requires total care. Resident is on a recreational diet and also fed by GT tube. Resident attends rehab (PT, OT) daily

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

cont'd

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

KINGSBROOK JEWISH MEDICAL CENTER
DAVID MINKIN REHABILITATION INSTITUTE

PROGRESS NOTES

ACCNT#: 1643155

DATE	TIME	SERVICE	NOTES
3/21/19	11	15 an Sad	PT report: stand in parallel bar with max assist, requires cueing to move leg, progress is observed. Today resident was showed how to lock wheelchair, needs directing. Recreation: resident is seen bedside not much participation as resident is engaged in off the floor Rehab. Resident is seen by Speech Therapist who works closely with resident's wife regarding his P.O intake. Social work. Family is supportive once resident is ready to return home he will go to his wife. Resident does not have HCP but unable to designate at this time. DNR, DNI explained and discussed with the family, they verbalized understand needs. The family will discuss Advance Directive and will inform SW/team of their decision. At this time resident is full code. No date for discharge at this time. Emotional support provided. Family verbalized gratefulness for all services. Grace Iner

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

FORM 4-1508 REV. 6/81 NS

KINGSBROOK JEWISH MEDICAL CENTER
DAVID MINKIN REHABILITATION INSTITUTE

PROGRESS NOTES

Name
Number
Loc/Sex/Age
Doctor/Ser.

DATE	TIME	SERVICE	NOTES

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

KINGSBROOK JEWISH MEDICAL CENTER

RUTLAND NURSING HOME

MINI-MENTAL STATE EXAMINATION

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

DATE OF TEST: 04 / 04 / 19 NAME OF EXAMINER: C. Dany, PA-S

DAY OF THE WEEK: Thursday

Give one point for each correct response, 0 for each incorrect answer

		PATIENT'S RESPONSE	SCORE	POINTS
Orientation:				
1. What is the:	Year	2019	1	1
	Season	?	0	1
	Date	?	0	1
	Day	Thursday	1	1
	Month	?	0	1
2. Where are we?	State	n/a	0	1
	County	n/a	0	1
	Town or city	n/a	0	1
	Hospital/nursing home	n/a	0	1
	Floor	unknown	0	1
Registration:				
3.	Name three objects, taking one second to say each. Then ask the patient to repeat all three. (Give one point for each correct answer. Repeat the answers until patient learns all three.)		0	3
Attention and calculation:				
4.	Serial sevens: Ask the patient to count backward from 100 by sevens, as 93, 86, 79, 72, 65 etc. (Stop after five answers: give one point for each correct answer.) Alternative: Spell WORLD backwards:		0	5
Recall:				
5.	Ask for names of the three objects learned in question 3. (Give one point for each correct answer)		0	3
Language:				
6.	Point to a pencil and a watch. Ask the patient to name each as you point.		0	2
7.	Ask the patient to repeat 'No ifs, ands, or buts'		0	1
8.	Ask the patient to follow a three-stage command: 'Take a paper in your right hand. Fold the paper in half. Put the paper on the floor.'		0	3
9.	Ask the patient to read and obey the following command: 'CLOSE YOUR EYES.' (Write in large letters.)		0	1
10.	Ask the patient to write a sentence of his or her choice. (The sentence should contain a subject and an object and should make sense. Ignore spelling errors when scoring.)		0	1
11.	Ask the patient to copy the design shown. (Give one point if all sides and angles are preserved and if the intersecting sides form a quadrangle.)		0	1
		Total	1	30

Educational Level -

The The Mini-Mental State Examination, which can be administered in the primary care setting in about 10 minutes will accurately identify patients who have cognitive impairment. A score of 20-24 generally suggests mild impairment; a score of 16-19, moderate impairment; and a score of 15 or less, severe impairment. Keeping track of a patient's scores over time will also document progression of the patient's cognitive impairment.

Form # 4-1262 11/96

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

KINGSBROOK JEWISH MEDICAL CENTER
RUTLAND NURSING HOME

ACCNT#: 1643155

Monthly Nurses' Note

March 2019 15P

1. MENTAL STATUS:
☑ ALERT ☐ ORIENTED: ☐ TIME ☐ PERSON ☐ PLACE ☐ DISORIENTED
☑ CONFUSED ☐ LETHARGY ☐ OTHER

2. COGNITIVE SKILL FOR DAILY DECISION MAKING:
☐ INDEPENDENT - DECISIONS CONSISTENT / REASONABLE
☐ MODIFIED INDEPENDENCE - SOME DIFFICULTY IN NEW SITUATIONS ONLY
☐ MODERATELY IMPAIRED - DECISION POOR; CUES SUPERVISION REQUIRED
☑ SEVERELY IMPARIED - NEVER / RARELY MADE DECISIONS
☐ OTHER

3. MEMORY RECALL ABILITY:
☐ CURRENT SEASON ☐ LOCATION OF OWN ROOM ☐ STAFF/FAMILY NAMES/FACES
☐ THAT HE/SHE IS IN A NURSING HOME ☑ NONE OF THE ABOVE IS RECALLED ☐ N/A

4. CHANGE IN COGNITIVE STATUS:
☑ NO CHANGE ☐ IMPROVED ☐ DETERIORATED ☐ N/A

5. HEARING PATTERNS:
☑ HEARS ADEQUATELY - NORMAL TALK, TV, PHONE
☐ MINIMAL DIFFICULTY WHEN NOT IN QUIET SETTING
☐ HEARING HIGHLY IMPAIRED / ABSENCE OF USEFUL HEARING ☐ N/A
HEARING CONSULT: ☐ YES ☐ NO

6. COMMUNICATION DEVICES:
☐ HEARING AID, PRESENT AND USED ☐ HEARING AID, PRESENT AND NOT USED ☐ OTHER ☑ N/A

7. COMMUNICATION:
☐ SPEECH CLEAR ☑ MILDLY IMPAIRED ☐ SEVERELY IMPAIRED
☐ LANGUAGE BARRIER ☐ OTHER ☐ N/A
SPEECH THERAPY ☐ YES ☐ NO

8. CHANGE IN COMMUNICATION:
☑ NO CHANGE ☐ IMPROVED ☐ DETERIORATED ☐ N/A

9. VISION PATTERNS:
☐ ADEQUATE - SEES FINE DETAIL ☑ IMPAIRED - SEES LARGE PRINT
☐ HIGHLY IMPAIRED - LIMITED VISION ☐ LEGALLY BLIND ☐ EYE MEDS_____
☐ CATARACTS: ☐ L ☐ R ☐ N/A
OPHTHALMOLOGIST CONSULT: ☐ YES ☐ NO ☐ N/A

10. VISUAL AIDE:
☐ GLASSES ☐ CONTACT LENSES ☐ LENSES IMPLANT ☐ N/A

11. RESPIRATORY:
☑ NO PROBLEM
RATE: ☐ DYSPNEA ☐ TACHYPNEA ☐ BRADYAPNEA
18 ☐ SOB ☐ ORTHOPNEA ☐ APNEA
RHYTHM: ☐ LABORED ☐ SHALLOW ☑ NORMAL
BREATH SOUNDS: ☐ CRACKLES (R) (L) ☐ WHEEZES (R) (L) ☐ DIMINISHED (R) (L) ☐ ABSENT

RESPIRATORY CONT'D

COUGH: ☑ NO ☐ YES ☐ PRODUCTIVE ☐ NON-PRODUCTIVE
☐ SPUTUM COLOR_____ ☐ CONSISTENCY_____
SUCTION: ☐ Q-SHIFT ☐ Q-TWO HOURS ☐ PRN

TRACHEOSTOMY: ☑ NO ☐ YES
TYPE OF TUBE:_____
SIZE OF TUBE :_____
TRACH CARE: ☐ N/A ☐ YES FREQUENCY:_____

INFECTION: ☑ NO ☐ YES ☐ TYPE:_____ REFER TO MD: ☐ YES ☐ NO
OXYGEN INHALATION: ☐ N/A ☐ YES ☐ NO RESPIRATORY CONSULT: ☐ YES ☐ NO
OXYGEN CONCENTRATION_____
☐ VENTIMASK ☐ NASAL CANNULA ☐ TRACH COLLAR VENTILATOR DEPENDENT ☐ YES ☐ NO
HUMIDIFIER: VENTILATOR SETTING:_____
☐ AEROSOL TREATMENT
NEBULIZER TREATMENT:

12. CARDIOVASCULAR: BP 145/90 P 75
RHYTHM: ☐ REGULAR ☐ IRREGULAR ☐ TACHYCARDIA ☐ BRADYCARDIA
PACEMAKER:
SITE:_____
READING:_____
READING WITH MAGNET:_____
REFER TO MD: ☐ YES ☐ NO ☐ N/A CARDIOVASCULAR CONSULT: ☐ YES ☐ NO ☐ N/A
IV LINE: - SPECIFY: SITE:_____ TYPE:_____
IV THERAPY: SOLUTION_____ IV LINE - SPECIFY:_____
IV SITE: ☐ NORMAL ☐ SWELLING ☐ ECCHYMOSED ☐ REDDENED ☐ PAINFUL
☐ OTHER_____

13. GASTROINTESTINAL:
ABD: ☑ SOFT ☐ DISTENDED ☐ FLAT ☐ TENDER ☑ NON-TENDER
BS: ☑ NORMAL ☐ HYPOACTIVE ☐ HYPERACTIVE ☐ ABSENT
INFECTION: ☐ YES TYPE:_____ ☐ NO
REFER TO MD: ☐ YES ☐ NO BOWEL MOVEMENTS: ☑ NORMAL ☐ CONSTIPATION ☐ LOOSE STOOL
GI CONSULT: ☐ YES ☐ NO ☐ N/A OSTOMY: - TYPE_____

14. NUTRITIONAL: ☐ REGULAR ☐ DIABETIC ☐ OTHER_____
ROUTE OF FOOD / FLUID INTAKE: ☑ PO ☑ GT ☐ PEG ☐ JT
APPETITE: ☐ GOOD ☐ FAIR ☐ POOR
WEIGHT: ☐ GAIN ☐ LOSS # OF LBS_____ ☑ NO PROBLEM
COMPLAINTS OF: ☐ NAUSEA ☐ VOMITING ☐ INDIGESTION ☐ DIARRHEA ☐ NONE
DIFFICULTY WITH: ☐ CHEWING ☐ SWALLOWING ☐ TASTING
TUBE FEEDING: ☐ NO ☑ YES TYPE_____ RATE:_____
DIET CONSULT NECESSARY: ☐ YES ☑ NO ☐ N/A

15. GENITOURINARY:
URINE: COLOR Amber CLARITY Clear ODOR: ∅
CATHETER: ☐ FOLEY (SIZE_____) ☐ TEXAS ☐ SUPRA-PUBIC ☐ CONTINENT ☑ INCONTINENT B/B
DIALYSIS: ☐ YES ☑ NO ☐ TESIO CATHETER ☐ AV SHUNT ☐ AV FISTULA
EVALUATION:
PATENCY: BRUITS ☐ YES ☐ NO THRILLS: ☐ YES ☐ NO
INFECTION: ☐ YES ☐ NO TYPE_____
REFER TO MD: ☐ YES ☐ NO TOILETING PROGRAM: ☐ YES ☐ NO
UROLOGIST CONSULT: ☐ YES ☑ NO ☐ N/A

16. SKIN:

TURGOR						
COLOR:	☑ NORMAL	☐ PINK	☐ ASHEN	☐ PALE	☐ CYANOTIC	☐ JAUNDICE
TEMP:	☐ HOT	☐ COOL	☐ COLD	☑ WARM		
	☐ MOIST	☐ DIAPHORETIC	☐ DRY	☐ CLAMMY		
RASH:	☐ YES	☑ NO	TREATMENT:	☐ YES ☐ NO	☐ N/A	
PRESSURE SORES:		☐ YES	☑ NO			
STASIS ULCER		☐ YES	☑ NO			
SURGICAL WOUND		☐ YES	☑ NO			
WOUND CARE CLINIC:		☐ YES	☑ NO			
RECEIVING TREATMENT:		☐ YES	☑ NO	☐ N/A		
EVALUATION:		☐ IMPROVING	☐ DETERIORATING	☐ NO CHANGE		
SURGICAL CONSULT:		☐ YES	☑ NO	☐ N/A		

17. ADL STATUS:

SELF-PERFORMANCE SCALE (SP) : 1

0. INDEPENDENT: HELP OR OVERSIGHT PROVIDED ONLY 1 OR 2 TIMES

1. SUPERVISION: OVERSIGHT, ENCOURAGEMENT OR CUING PROVIDED 3+ TIMES OR -SUPERVISION PLUS PHYSICAL ASSISTANCE PROVIDED 1 OR 2 TIMES

2. LIMITED ASSISTANCE: RESIDENT INVOLVED IN ACTIVITY: RECEIVED (HANDS ON HELP) IN GUIDED MANEUVERING OF LIMBS OR OTHER NON-WEIGHT BEARING ACTIVITY.
ASSISTANCE 3+ TIMES, - OR -MORE. HELP PROVIDED ONLY 1 TO 2 TIMES

3. EXTENSIVE ASSISTANCE: WHILE RESIDENT PERFORMED PART OF ACTIVITY, HELP OF THE FOLLOWING TYPE (S) WAS PROVIDED 3 OR MORE TIMES SHIFT/DAY
- WEIGHT-BEARING SUPPORT, STAFF HANDS ON ASSISTANCE DURING TRANSFER / AMBULATION.
- FULL STAFF PERFORMANCE DURING PART BUT NOT ALL OF PAST 7 DAYS.

4. TOTAL DEPENDENCE: FULL STAFF PERFORMANCE DAILY.

8. THE ADL DID NOT OCCUR

ADL SUPPORT SCALE (SP) : 2

0. NO SETUP OR PHYSICAL HELP FROM STAFF

1. SETUP HELP ONLY

2. ONE PERSON PHYSICAL ASSIST

3. TWO OR MORE PERSONS PHYSICAL ASSIST

8. THE ADL DID NOT OCCUR

ADLS	SP 1	SP 2
BED MOBILITY: How resident moves to and from lying position, turns side to side and positions body while in bed.	4	2
TRANSFER: How resident moves between surfaces, to/from bed, chair, wheel chair, standing position. (Exclude to/from bath/toilet.)	4	3
WALKING: How resident walks between locations — in own room	8	8
How resident walks — in corridor on unit	8	8
LOCOMOTION: How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.	4	2
EATING: How resident eats and drinks (regardless of skill).	4	2
TOILET USE: How the resident uses the toilet room or commode, bedpan, urinal; transfers on/off toilet, cleans, changes pad, manages ostomy or catheter, adjusts clothes.	4	2
PERSONAL HYGIENE: How the resident maintains personal hygiene, including coombing hair, brushing teeth, shaving, applying make-up, washing/drying face, hands and perineum. Exclude bath and showers.	4	2

SELF-PERFORMANCE SCALE (SP):3

0. Independent: No help provided
1. Supervision: Oversight help only
2. Physical help limited to transfer only
3. Physical help in par of bathing activity
4. Total dependence
8. The ADL did not occur

ADL SUPPORT SCALE (SP):4

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two or more persons physical assist
8. The ADL did not occur

ADL	SP3	SP4
BATHING: How resident took full body bath, transferred in/out of tub/shower. (Exclude washing of back and hair)	4	3.

ASSISTIVE DEVICES: ☐ YES ☒ NO

SPLINTS/BRACES/PROSTHESIS: SITE/LIMB_____ TYPE:_____

SIDE RAILS: ☐ ONE ☐ TWO ☒ NONE

RESTRAINTS: ☐ YES ☒ NO

TYPE:_____ REASON:_____

PAIN MANAGEMENT

0 NONE 2 4 MODERATE 6 8 10 WORST

FOR LEVEL 2 OR HIGHER CHECK TYPE OF INTERVENTION

☑ MEDICATION ☐ OTHER

Tylenol 650mg Q8 Hrs.

PSYCHOTROPIC MEDICATIONS: ☐ YES (Refer to Psychotropic Meds Note) ☒ NO

BEHAVIORAL EPISODES: ☐ YES (Refer to Behavioral Note Dated_____) ☒ NO

COMMENTS: (For example: Critical Values, Acute Episodes, Non-Compliant Behavior, Psycho-social issues)_____

Resident alert and verbally responsive, no S/S of distress G.T feeding Glucerna 1.2, Aspiration precautions Maintained G.T Site clean and dry, H/O diabetes, Checking Monitoring TID in progress with Insulin therapy, no S/S of Hypo/Hyperglycemia, Tylenol Q8 Hrs Given for pain ordered. no ill effects from Medication noted, fluid given via G.T to Maintain Epf Hydration, positioning done. R/O Hrly to maintain Skin integrity and prevent D.U's, General Condition Stable.

Ann Joseph, LPN 3/29/19.

Nurse's Signature/Date

Supervisor's Signature/Date

KJMC-MS04 11/03 (Please attach this page to this form)

FRANCISQUE ,JEAN M 71
1256 WUBSHET, BERHANE,
VAS PT#: 11045967 DOB: 0
MR#: 0370519 PH#:
REG DT: 03/13/19 TIME 09:34

KINGSBROOK JEWISH MEDICAL CENTE
DAVID MINKIN REHABILITATION INSTITU

[NUTRITION PROGRESS NOTE]

DATE	TIME	SERVICE	NOTES
3/14	19	Nutrition	Recommend continue Glucerna 1.0 @ 85 ml/h. flush with 55 ml H2O q hrly = 1800 cals/90 gms prot/2235 ml fld/day Continue Proform 30 ml tid/day = 200 cals/30 gms prot. for total 2000 Cals/120 gms prot, 2235 ml fld/day. Cal/prot intake via GT and fluids exceeds nutrient needs. Weekly wt requested.
	11:30	pm	
			[illegible] RDN CDN #97
3/14	19	Nutrition	DM uncontrolled - Levemir was increased from 20 units to 22 units q 12 hrs. noted. Pt was evaluated by Speech to continue GT/PEG feed as main source of nutrition/hydration (See Speech Consult dtd 3/8 & 3/11. Continue to mon tolerance to feed.
	2:40	pm	
			[illegible] RDN CDN #97

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

FORM 4-1506 REV. 6/81 HS

FRANCISQUE ,JEAN M 71
1256 WUBSHET, BERHANE,
VAS PT#: 11045967 DOB:
MR#: 0370519 PH#:
REG DT: 03/13/19 TIME 09:34

ame
umber
/Ag
Doctor/Ser.

KINGSBROOK JEWISH MEDICAL CENT
DAVID MINKIN REHABILITATION INSTITUTE

[NUTRITION PROGRESS NOTE]

DATE	TIME	SERVICE	NOTES
4/4/19		Nutrition	Res started on full Pureed diet @ lunch meal D/c Recreational leads @ lunch Observe for meal deceptions

YOUR PROGRESS NOTES MUST JUSTIFY TODAY'S HOSPITAL STAY. IF YOU ARE RECOMMENDING ANY ALTERNATE LEVEL OF CARE, CALL SOCIAL SERVICE, EXTENSION 5300-5305 IMMEDIATELY.

FORM 4-1508 REV. 6/81 HS

KINGSBROOK
JEWISH MEDICAL CENTER
RUTLAND NURSING HOME
ADULT NUTRITION ASSESSMENT
[X] INITIAL [ ] ANNUAL

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

DIAGNOSES/PAST MEDICAL HISTORY: Stroke c̄ hemorrhagic conversion PEG placed on 2/22/19 HTN DM

DIET ORDER/SUPPLEMENTS: NA

Diet Rx/ Supplements Transcribed Correctly in MAR: Y/ N; If No, RN/LPN notified? RN/LPN Name:

Food Allergies/Intolerances/Preferences (including cultural/religious): NA

ENTERAL NUTRITION: FORMULA: Glucerna 1.2 CONTINUOUS: 1500 ML @ 55 ML/HR
BOLUS: ____ ML Q ____ HRS
WATER FLUSH: ____ ML / ____ HR AND/OR 50 ML Q SHIFT (1210)
PROFORM: 30 ML: Q AM ___, BID ___, TID ___, NONE ___
TF PROVIDES: 1800 KCAL, 90 GM PROTEIN, 2573 ML FLUID

HT: 67 WT: 144 Lbs IBW RANGE: 148 ± 10% %IBW: — BMI= 23 (Normal)/ Underweight/Overweight/Obesity I / II / III
ADJUSTED BODY WT= — UBW/WT Hx: NA
Weight change: ____ lbs x 1mo; —
Significant Insignificant Planned Unplanned Insidious (8.5% x 6 months) Stable
Related to: —
APPETITE/INTAKE: ___ GOOD (75-100%) ___ FAIR (50-75%) ___ POOR (<50%) NA
FEEDING ABILITY: ___ FEEDS SELF ___ PARTIAL ASSIST ___ SPOON FED/ TOTAL ASSIST ✓ TUBE FEEDING ___ TPN
DENTITION: X OWN TEETH ___ EDENTULOUS ___ DENTURES

SKIN ULCERS: [X] NONE, [X] PRESSURE, ___ VASCULAR, OTHER

LOCATION	LT heel			
STAGE	DTI			

NUTRITIONAL CONCERNS: ___ NONE NOTED
___ Nausea ___ Vomiting ___ Diarrhea ___ Constipation
✓ Swallowing Difficulty ___ Chewing Difficulty
___ Edema/Potential for weight fluctuation due to fluid shifts
___ Pain affecting intake
Other

SIGNIFICANT LAB DATA & DATE: 3/8/2019 BS 253 BUN 23H Cr 0.8 Na 131L K 4.2 CBC 7.6 Alb 2.7L Glu 141/146 HbA1c 6.3
ALBUMIN 3/8/19 Date 2.7 PREALBUMIN — Date Vit D 15↓
Date: ____ HgbA1C ____ eAG ____ Date Range ____
Fingerstick (mg/dL): 6 AM ____ 11 AM ____ 4.30 PM ____

DRUG-NUTRIENT INTERACTIONS/ IV ABT: H/H 9/12.9L MCV 83.7 wnl ASA Metoprolol Insulin

ESTIMATED DAILY NUTRITIONAL REQUIREMENTS:
CALORIES: 1963 - 2291 KCAL (BASED ON 30 - 35 KCAL/KG BODY WT)
PROTEIN: 98 - 131 GM (BASED ON 1.5 - 2.0 GM/KG BODY WT)
FLUID: 1963 - 2291 ML (BASED ON 30 - 35 ML/KG BODY WT)

MDS 3.0 CARE AREA ASSESSMENT (CAA): [ ] None (✓) Nutritional Status [X] Feeding Tube [X] Fluid Maintenance

EVALUATION: 71 y/o male admitted c̄ GTF of Glucerna 1.2 1500ml @ 55ml c̄ 50ml QH water flush. CBW 144 BMI 23 wnl, SLP eval done 3/8/19 Meds reviewed: Insulin Labs reviewed Na↓ - monitor, Alb 2.7 & Vit D 15 - Will benefit from proform & Vit D. Has DTI left heel DTI.

PLAN: — continue current GTF
— Add proform 30ml BID
— Monitor GTF tolerance / wt / labs / skin / hydration / SLP eval

[signature] 502 3/9/19 3:32
SIGNATURE/TITLE PAGER# DATE TIME

See multidisciplinary care plans and patient/family education forms for additional information

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
LTCM/WUBSHET, B. M CATHOLIC TW 1013B
ACCNT#: 1643155

KINGSBROOK

Rutland Nursing Home

Must be completed on admission, monthly and with any significant change

PRESSURE ULCER RISK ASSESSMENT (BRADEN SCORE)					
Sensory Perception	**Moisture**	**Activity**	**Mobility**	**Nutrition**	**Friction & Shear**
Completely limited 1	Constantly moist 1	Bedfast 1	Completely immobile 1	Very poor 1	Problem
Very limited 2	Very moist 2	Chairfast 2	Very limited 2	Inadequate 2	Potential problem
Slightly limited 3	Occasionally moist 3	Walks occasionally 3	Slightly limited 3	Adequate 3	No apparent problem 3
No impairment 4	Rarely moist 4	Walks frequently 4	No limitations 4	Excellent 4	

Date/Year	3/6/19					
Sensory Perception	3					
Moisture	3					
Activity	2					
Mobility	3					
Nutrition	2					
Friction & Shear	3					
Score	16					
Signature & Title	Joseph RN					

RESIDENTS WHO SCORE 18 OR LESS ARE AT RISK FOR PRESSURE ULCERS
INITIATE / MAINTAIN PRESSURE ULCER PREVENTION PROTOCOL AND REFER TO NUTRITION SERVICE

Check Prevention Protocol Initiated:

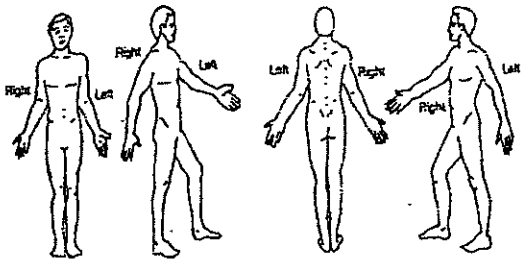
- ☐ Turn & position every 2 hours;
- ☐ Pressure relieving surface;
- ☐ Adaptive devices for positioning
- ☐ Foley catheter
- ☐ Other_____
- ☑ Moisture barrier to perineal area;
- ☑ Skin checks every shift by C N A
- ☐ Fecal pouch
- ☐ Supplement / nourishment

INGSBROOK

WEEKLY
Ulcer / Wound Evaluation Record

RNH 03/05 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

Indicate location of the ulcer / wound by placing an "X" in red on the



Pres

Stage 1 Defined area of persist... ulcer may appear with persistent red, blue, or purple hues.

Stage 2 Partial thickness skin loss involving epidermis, dermis or both.

Stage 3 Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia.

Stage 4 Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures.

Unstageable If the wound bed is not totally visible because it is covered with eschar or slough then the wound is marked unstageable. If it is only partially covered then stage the wound.

Date of onset of Ulcer/Wound: 3/6/19 ☐ **Nosocomial** ☑ **Community Acquired**

Ulcer / wound type: ☐ **Pressure Ulcer** ☐ **Venous Stasis Ulcer** ☐ **Arterial ulcer** ☐ **Surgical Wound** ☐ **Unstageable**
☐ **Diabetic ulcer** ☐ **Skin Tear** ☑ **Deep Tissue Injury**

WEEKLY DATE →	3/7/19			
Location / Site	Lt Heel			
Stage:	sDTI			
Size (Length x width) in cm	2.5 cm x 3 cm	cm x cm	cm x cm	cm x cm
Depth (cm)	0 cm			
Drainage	—			
Odor	—			
Color	dark grayish			
Wound Bed	—			
Undermining/Tunneling (Y/N)	—			
Debridement Date	—			
WOUND PAIN SCORE	0/10			
Support Surface	Alternair			
RN/LPN Initials →				

KEY:

Color	P=pink/red	S=slough	E=eschar	N=necrotic
Exudate	S=serosanguinous	P=pus	N=none	
Odor	F=foul	M=mild	N=none	
Surrounding Skin	E=erythema	M=maceration	I-induration	
Wound Bed	S= slough	E= eschar		
Wound Pain Score	NUMERIC = 0 to 10	or	FACES= F 0 to 10	or FLACC= FL 0 to 10 or PAINAD= 0 to10

Rev June 07. BS 10.10. 8/2016

KINGSBROOK JEWISH MEDICAL CENTER

Pain Asses

Complete on admission f
on PAIN SCREENING que

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC 1013B
LTCM/WUBSHET, B.

Date: 3/19/19 Time. ACCNT#: 1643155

Current PAIN SCORE (circle) 0 1 2 3 4 5 6 7 8 9 10 Other:_____

Patient's ACCEPTABLE Pain Score (circle) 0 1 2 3 4 5 6 7 8 9 10 Other:_____

PAIN SCALE USED (circle) NUMBER PAINAD FACES FLACC

LOCATION (circle) Head Neck Abdomen Chest Right Arm Left Arm Right Leg Left Leg
Back Incision Perineal Other:_____

DESCRIPTION (circle) Aching Bloating Burning Cramping Comes and Goes Constant Cutting
Dull Numbing Pressing Pulling Radiating Sharp Shooting Soreness Stabbing Throbbing Tightness
Other:_____

ONSET: When did this pain start? Date:_____Time:_____(military time)

DURATION: How long did this pain last? _____hours / days (circle)

WHEN does this usually occur? (circle) DAY EVENING NIGHT Other:_____

What INCREASES the pain? (circle) Lifting Sitting Walking Bending Pulling Pushing
Resting After Exercise Other:_____

What RELIEVES the pain? (circle) Medication Specify:_____
Resting Swimming Massage Aromatherapy Music Ice Pack Heat Pack Position Change Other:_____

What are the EFFECTS of pain? (circle) Symptoms that accompany it Poor appetite Sleep problems
Limited mobility Irritability Anger Withdrawal Loss of concentration Issues with personal relationships
Other:_____

Nurse Signature	Printed Name

NEW PAIN, PAIN IN OTHER LOCATIONS , POST-PROCEDURE OR POST-OP PAIN (Use below)

Date: _____ Time: _____

Current PAIN SCORE (circle) 0 1 2 3 4 5 6 7 8 9 10 Other:_____

Patient's ACCEPTABLE Pain Score (circle) 0 1 2 3 4 5 6 7 8 9 10 Other:_____

PAIN SCALE USED (circle) NUMBER PAINAD FACES FLACC

LOCATION (circle) Head Neck Abdomen Chest Right Arm Left Arm Right Leg Left Leg
Back Incision Perineal Other:_____

DESCRIPTION (circle) Aching Bloating Burning Cramping Comes and Goes Constant Cutting
Dull Numbing Pressing Pulling Radiating Sharp Shooting Soreness Stabbing Throbbing Tightness
Other:_____

ONSET: When did this pain start? Date:_____Time:_____(military time)

DURATION: How long did this pain last? _____hours / days (circle)

WHEN does this usually occur? (circle) DAY EVENING NIGHT Other:_____

What INCREASES the pain? (circle) Lifting Sitting Walking Bending Pulling Pushing
Resting After Exercise Other:_____

What RELIEVES the pain? (circle) Medication Specify:_____
Resting Swimming Massage Aromatherapy Music Ice Pack Heat Pack Position Change Other:_____

What are the EFFECTS of pain? (circle) Symptoms that accompany it Poor appetite Sleep problems
Limited mobility Irritability Anger Withdrawal Loss of concentration Issues with personal relationships
Other:_____

Nurse Signature	Printed Name

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#. 1643155

RUTLAND NURSING HOMI

PAIN MANAGEMENT
NURSES NOTES

DATE	TIME	
3/12/19	11P-7A	Resident Started on Tylenol 650mg PO Q8Hrs for pain to Left Knee, Medicated with effect, will continues to monitor, Stable. GFSept LPN
3/19/19	11P-7A	Alert; Tylenol 650mg PO continues for pain with effect, Stable; will Continue to monitor GJSept LPN
3/26/19	11P-7A	Pain Management Continues with effect, resting Comfortably, ~~Effect~~ monitoring continues. GJSept LPN
4/3/19	11P-7A	Alert, pain Management in progress, Scale 0/10, Safety maintained, Stable Condition. GJSept, LPN

KINGSBROOK
JEWISH MEDICAL CENTER
Department of Pharmacy
Rutland Nursing Home

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
LTCM/WUBSHET, B. M CATHOLIC TW 1013B
ACCNT#: 1643155

Medication Regimen Review: Consultant Pharmacist's Signature

Date	Activity	Consultant Pharmacist Signature/Title	Consultant Pharmacist Name Print/Stamp	Notes
3/7/19	Medication Regimen Review		Kathryn Bress, B.S., Pharm.D. Pharmacy Practice Resident (PGY-I) Department of Pharmacy Pager: 894, Ext. 6659	
	Medication Regimen Review			
	Medication Regimen Review			
	Medication Regimen Review			
	Medication Regimen Review			
	Medication Regimen Review			
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	Medication Regimen Review			
	Medication Regimen Review			
	Medication Regimen Review			
	Medication Regimen Review			

** DO NOT REMOVE. Permanent part of the chart**
Place in CONSULT section of the chart

Guardian Consulting Services, In

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

Medication Regimen Re

Resident Name: ______________________

Date	Activity	Consultant Pharmacist Signature/Title	Consultant Pharmacist Name Print/Imprint	See DRR Printout for Recommendations
3/25/19	Drug Regimen Reviewed	[signature]	Alina Galimova, Pharm.D.	[ ] Recommendation(s) [x] No Recommendations
	Drug Regimen Reviewed			[ ] Recommendation(s) [ ] No Recommendations
	Drug Regimen Reviewed			[ ] Recommendation(s) [ ] No Recommendations
	Drug Regimen Reviewed			[ ] Recommendation(s) [ ] No Recommendations
	Drug Regimen Reviewed			[ ] Recommendation(s) [ ] No Recommendations
	Drug Regimen Reviewed			[ ] Recommendation(s) [ ] No Recommendations
	Drug Regimen Reviewed			[ ] Recommendation(s) [ ] No Recommendations
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	Drug Regimen Reviewed			[ ] Recommendation(s) [ ] No Recommendations
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	Drug Regimen Reviewed			[ ] Recommendation(s) [ ] No Recommendations
	Drug Regimen Reviewed			[ ] Recommendation(s) [ ] No Recommendations

***DO NOT REMOVE* Maintain on chart in CONSULT section.**

See DRR Printouts for Individual Recommendations

Francisque, Jean

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
(M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

KINGSBROOK JEWISH MEDICAL CENTER
RUTLAND NURSING HOME
DEPARTMENT OF REHABILITATION MEDICINE
RECREATION THERAPY
INITIAL ASSESSMENT FORM

Resident Name: Francisque, Jean
Birthdate 9/16/47 Age 71
Birthplace Haiti
Languages: Primary: Creole Secondary: English
Highest Education Level Master's Degree
Marital Status: Married Children: 3
Family Advocate: Gladys Francisque
Former Occupation Professor
Registered Voter Yes No
Admitted From: Kings County Hospital
Diagnosis (Verbatim from Medical Records) Stroke c hemiplegia, Coronary Artery Dis, DM

Check (✓) all items which apply

☑ Alert ☐ Oriented- ☑ person ☑ place ☐ time ☐ Confused ☐ Comatose

AMBULATORY STATUS:
☐ No Aid ☐ Cane ☐ Walker ☑ W/C ☐ propels self ☐ does not propel self ☐ needs assistance for long distances

MEMORY: ☑ Short Term Intact ☐ Long Term Intact ☐ Forgetful ☐ Unable to evaluate

COGNITIVE STATUS:	GOOD	FAIR	POOR
Understands procedures	☐	☑	☐
Follows directions	☐	☑	☐
Concentration	☐	☑	☐
Decision Making	☐	☑	☐
Judgement	☐	☐	☐
Visual Awareness	☑	☐	☐
Auditory Awareness	☑	☐	☐
Object Recognition	☑	☐	☐

SOCIAL STATUS:	YES	NO
Initiates Conversation	☐	☑
Engages in Conversation	☑ Often	☐
Contact with Family/Friends	☑	☐
At ease interacting with others	☑ At times	☐
Appropriate social/verbal responses	☑ At times	☐
Appropriate non-verbal responses	☑	☐
Monopolizes attention	☐	☑
Withdrawn	☐	☑
Verbally Abusive	☐	☑
Physically Abusive	☐	☑
Disruptive	☐	☑

COMMUNICATION:
Speech: ☐ Clear ☐ Normal Volume ☑ Low Volume ☐ Unclear ☐ No Speech
Aphasic: ☐ Expressive ☐ Receptive ☐ Global
Vision: ☑ Normal ☐ Impaired (sees large print) ☐ Glasses - Yes / No ☐ Legally Blind
Hearing: ☑ Good ☐ Fair ☐ HOH ☐ Hearing Impaired L / R ☐ Wears Aide Yes / No
Mode of Communication: ☑ Speech ☐ Writing ☐ Gestures ☐ Communication Board
☑ Incontinent ☐ Bowel ☐ Bladder ☑ Both

LEISURE VALUES AND ATTITUDES:
Socialization Levels: ☑ Active ☑ Spectator ☑ Large Group ☑ Small Group ☑ 1:1 Interaction ☑ Independent

Close contact with Relatives/Friends ☐ Yes ☐ No
Most valued leisure time activities and why: Engaging parties
Attitude towards participating at present Limited Variety
Resident/Family education needs: Wellness
DIET: Puree ALLERGIES

Form 4-1602.5M Rev. 8/2000

RECREATION INTEREST SURVEY:

Code: Check (✓) all items which apply

SOCIAL	Past	Current
Shopping	☑	☐
Trips/Travel	☑	☐
Club	☐	☐
Conversing	☑	☑
Pets	☐	☐
Telephone	☑	☐

COMMUNITY SERVICE		
Resident Council	☐	☐
Organizations	☑	☐
Volunteer Work	☐	☐

Comments: _____

CREATIVE/ CULTURAL		
Creative Writing	☐	☐
Singing	☑	☐
Dancing	☐	☐
Poetry	☐	☐
Cooking	☐	☐

Other _____

SPECTATOR/ PASSIVE		
Concerts	☑	☐
Parties	☑	☐
Movies/Video	☑	☐
Athletic Events	☑	☑
Watching TV	☑	☑
Listening to Radio	☑	☑

Other/Specify _____

INTELLECTUAL	Past	Current
News & Views	☑	☐
Adult Education	☐	☐
Quiz Games	☐	☐
Discussion/Lectures	☑	☐

ARTS/ CRAFTS		
Needle Crafts	☐	☐
Knitting/Crocheting	☐	☐
Painting/Drawing	☐	☐

Other _____

GAMES/ SPORTS/ EXERCISE		
Bingo	☐	☐
Bowling	☑	☐
Cards	☑	☐
Checkers	☐	☐
Chess	☑	☐
Basketball	☐	☐
Horse Racing	☐	☑
Exercise	☐	☑

Other _____

SPIRITUAL		
Religious Service	☑	☐

Orientation Catholic

Needs _____

PREFERRED ACTIVITY SETTING	
Own Room	☑
On Unit	☑
Off Unit	☐
Outdoors	☐

PERSONAL PREFERENCE REGARDING SCHEDULE: ☑ Morning ☑ Afternoon ☐ Evening

	STRENGTHS	LIMITATIONS
Social	answers basic questions of hers	_____
Cognitive	alert/oriented to person/place	_____
Physical	_____	wheelchair dependent
Affective	_____	_____
Leisure	_____	limited variety

TREATMENT PLAN

Problems/Needs: Resident needs to adjust to nursing home environment

Goals: Short Term Resident will answer 1-2 basic questions during 1:1 visits 1x per week over next 90 days

Long Term Resident will become adjusted to Nursing home environment.

Has plan been formulated with resident? ☑ Yes ☐ No (reason) _____

☐ Resident unable to participate in interview at this time ☐ Family unavailable for interview at this time

Has treatment plan been discussed with family/designated representative? ☑ Yes ☐ No

Resident Signature X [illegible] (Resident's spouse)

COMMENTS: Above information was provided by Resident's family member.

[illegible] Signature/Title [illegible] Rec Thera Date 3/14/19

03/07/20 19:29

KINGSBROOK JEWISH MEDICAL CENTER
585 SCHENECTADY AVENUE
BROOKLYN, NEW YORK 11203

AUTO RESULT REPORT
PAGE 1

NAME: FRANCISQUE,JEAN
MRN : X370519
DOB : 7

LOC: TW
ROOM:TW-1013B
DR: WUBSHET, BERHANE

AGE: 71Y SEX: M

H78832 COLL: 03/07/2019 16:40 REC: 03/07/2019 17:57 PHYS: WUBSHET, BERHANE

URINE MICROSCOPIC			
RBC Microscopy	NotPrsnt [NP]	/hpf	{KJ}
WBC Microscopy	*1 to 4 [NP]	/hpf	{KJ}
Epithelial Cells Urn	NotPrsnt [NP]	/hpf	{KJ}
Bacteria Urine	*MANY [NP]	/hpf	{KJ}
CASTS	NotPrsnt [NP]	/lpf	{KJ}
Path Casts Urine	NotPrsnt [NP]	/lpf	{KJ}
Yeast Cells Urine	NotPrsnt [NP]	/hpf	{KJ}
Crystals Urine	NotPrsnt [NP]	/hpf	{KJ}
Sperm Urine	NotPrsnt [NP]	/hpf	{KJ}

{KJ} = Performed at Kingsbrook Jewish Med. Ct.,Brooklyn, NY 11203

03/10/20 03:37

KINGSBROOK JEWISH MEDICAL CENTER
585 SCHENECTADY AVENUE
BROOKLYN, NEW YORK 11203

AUTO RESULT REPORT
PAGE 1

NAME: FRANCISQUE,JEAN
MRN : X370519
DOB :0

LOC: TW
ROOM:TW-1013B
DR: WUBSHET, BERHANE

AGE: 71Y SEX: M

F40407 COLL: 03/08/2019 05:32 REC: 03/08/2019 07:19 PHYS: WUBSHET, BERHANE

HEMOGLOBIN A1C

HEMOGLOBIN A1C	*11.0	[3.9-6.1]	%

Reference range: <5.7
Unit: % of total Hgb
(NOTE)

For someone without known diabetes, a hemoglobin A1c value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test. For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1c targets should be individualized based on duration of diabetes, age, co-morbid conditions and other considerations. Currently, no consensus exists for use of hemoglobin A1c for diagnosis of diabetes for children.

EST.AVE.GLU	269	mg/dL

Unit: (mg/dL)

3/11/19

03/08/20 10:40

KINGSBROOK JEWISH MEDICAL CENTER
585 SCHENECTADY AVENUE
BROOKLYN, NEW YORK 11203

AUTO RESULT REPORT
PAGE 1

NAME: FRANCISQUE,JEAN
MRN : X370519
DOB : [illegible]

LOC: TW
ROOM:TW-1013B
DR: WUBSHET, BERHANE

AGE: 71Y SEX: M

F40407 COLL: 03/08/2019 05:32 REC: 03/08/2019 07:19 PHYS: WUBSHET, BERHANE

VIT D(25 HYDROXY)				
VIT D(25 OH) TOTAL	*15.49	[30-100]	ng/mL	{KJ}

{KJ} = Performed at Kingsbrook Jewish Med. Ct.,Brooklyn, NY 11203

will start
Ergocalciferol
3/8/19

03/08/20 08:35

KINGSBROOK JEWISH MEDICAL CENTER
585 SCHENECTADY AVENUE
BROOKLYN, NEW YORK 11203

AUTO RESULT REPORT
PAGE 1

NAME: FRANCISQUE,JEAN
MRN : X370519
DOB : C

LOC: TW
ROOM:TW-1013B
DR: WUBSHET, BERHANE

AGE: 71Y SEX: M

F40407 COLL: 03/08/2019 05:32 REC: 03/08/2019 07:19 PHYS: WUBSHET, BERHANE

COMP METABOLIC PANEL				
GLUCOSE	*253	[80-115]	mg/dl	{KJ}
UREA NITROGEN	*23	[8-20]	mg/dl	{KJ}
CREATININE	0.8	[0.7-1.2]	mg/dl	{KJ}
SODIUM	*131	[136-145]	mEq/L	{KJ}
POTASSIUM	4.2	[3.5-5.1]	mEq/L	{KJ}
CHLORIDE	*92	[98-107]	mEq/L	{KJ}
CARBON DIOXIDE	27	[22-32]	mEq/L	{KJ}
CALCIUM	8.5	[8.4-10.2]	mg/dl	{KJ}
TOTAL PROTEIN	*5.7	[6.0-7.8]	g/dl	{KJ}
ALBUMIN	*2.7	[3.2-4.6]	g/dl	{KJ}
AST(SGOT)	34	[10-42]	U/L	{KJ}
ALK.PHOSPHATASE	*94	[32-92]	U/L	{KJ}
TOTAL BILIRUBIN	0.5	[0.2-1.0]	mg/dl	{KJ}
ALT(SGPT)	*82	[10-40]	U/L	{KJ}
HEMOLYSIS INDEX	0	[0-2]		{KJ}
LIPID PANEL				
CHOLESTEROL	141	[140-200]	mg/dl	{KJ}
TRIGLYCERIDES	146	[35-160]	mg/dl	{KJ}
HDL CHOLESTEROL	36	[29-71]	mg/dl	{KJ}
LDL (CALCULATED)	76	[0-130]	mg/dl	{KJ}
hTSH	1.80	[0.34-5.6]	uIU/ml	{KJ}

{KJ} = Performed at Kingsbrook Jewish Med. Ct.,Brooklyn, NY 11203

W 3/8/19

David Minkin Rehabilitation In[illegible]
Kingsbrook Jewish Medical Cent

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

WEIGHT CHART

Date	Weight	Remarks	Date	Weight	Remarks
3/6/19	144 lbs	Admission		Weekly	Weight
3/4/19	141.3 lb		3/6/19	144 lbs	
			3/13/19	136 lbs	
			3/20/19	140.9 lb	
		-	3/29/19	141.6 lb	
			4/3/19	141.3 lb	

rm #4-257 - 11/75

Kingsbrook Jewish Medical Center
Rutland Nursing Home
David Minkin Plaza at 585 Schenectady Avenue
Brooklyn, NY 11203-1891

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

KIN
JEWISH

RESIDENT RISK OF ELOPEMENT EVALUATION

To be completed for all new admissions prior to initial CCP meeting and for all residents initially and when condition changes

		DATE: 2/6/19		DATE:		DATE:		DATE:	
		YES	NO	YES	NO	YES	NO	YES	NO
1a	Is the resident ambulatory?		/						
1b	Is the resident able to wheel self in w/c?		/						
	If "NO" for both questions # 1a and 1b → STOP and sign (no risk of elopement)								
2	Is the resident a candidate for pass to leave RNH without supervision?		/						
	If "YES", document so in the care plan and follow Pass Policy								
	If "NO", answer below								
3	Is the resident at risk for elopement in the judgement of the team?		/						
	If "YES", follow the policy re: Elopement Prevention and document in the Care Plan. Enter name on list of residents at risk for elopement								
	Signatures: Nursing								
	Social Worker								
	Other: (specify)								

Comments:

RUTLAND NURSING HOME
Resident Personal Property List

RNH 03/05/19 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

Resident Name:	
Room#:	
N= New Clothing	
U= Used Clothing	

N/U	AMT	DESCRIPTION	N/U	AMT	DESCRIPTION	N/U	AMT	DESCRIPTION
		Bathroom			Jewelry			Slippers
		Bed Jacket	N	1	Nightgown/Pajamas			Socks
		Belt			Panties			Suits -2 piece
		Blouse			Pantyhose			Sweater
		Bra			PrayerBook/Religious			Sweat Suit Pants
		Coat (wool/leather)			Purse/Pocketbook			Sweat Suit Top
		Dentures			Scarf	U	3	T-Shirt
		Dress	N	3	Shirt			Tie
		Eye Glasses			Shoes			Trousers/Pants
		Gloves			Shorts			Undershirt/Vest
		Hairbrush/comb			Skirt			Underwear - Men
		Hat			Slip			Wallet
		Jacket (spring/winter)			Radio			Wheel Chair
		Television Model:	N	3	Pillows.			Walker
			N	4	Pillow Case			Cane
		TV Serial#:	N	3	PANTS			Other Assistive Devices:

Amt of Money/Cash

Amt kept by Resident Amt secured in safe

I hearby certify that the above is a correct list of belongings and understand that the Nursing Home is not responsible for clothing money, jewelry, watch false teeth glasses or other articles retained by the resident or brought to the resident while in the Nursing Home. In the event that I lose behold, I understand that my belongs will be placed in storage for no more than 30 days.

Katia' Francisque (daughter) — Signature Resident/Family member — Date 3/10/19

[signature] — Inventoried by - Staff member Title & Signature — Date 3/10/19

Placed in storage by - Staff member Title & Signature — Date

___ Resident/Family will pick up clothes and items from the Linen and Laundry Dept. by_____

___ Resident/Family requests that clothes and items be donated to the facility

___ Resident/Family requests that clothes and items be discarded.

Social Worker Signature — Date

White Copy-Chart Yellow Copy-Resident/Family Member Pink-Social Work Blue-Linen&Laundry/Chart

property0904

RUTLAND NURSING HOME
585 SCHENECTADY AVENUE, BROOKLYN, NY 11203

NOTICE OF TRANSFER OR DISCHARGE

DATE 3/6/19 **RESIDENT'S NAME** Jean Francisque **RM #** 1013B

The anticipated date of transfer or discharge is 4/6/2019

Resident to be transferred/discharged to: Home address

The Comprehensive Care Plan Team has determined that the above mentioned Resident's needs can no longer be met at the FACILITY for the following reasons:

____The safety or health of residents in the facility would be endangered, the risk to others is more than theoretical and all reasonable alternatives to transfer of discharge have been explored and have failed to address the problem based on the following _____

_____

____The resident's health improved sufficiently so that the resident no longer needs the services of the facility based on the following: _____

_____

___ The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or _____

___The facility cannot meet the needs of the resident due to the following: _____

_____

A. The Resident and/or Designated Representative have the right to appeal this decision. The resident has the right to an evidentiary hearing to appeal the proposed discharge or transfer by contacting the following:

1. By Mail - The Department of Health Centralized Complaint Intake Program (CCIP)
   875 Central Avenue, Albany, NY 12206
   or
   Phone: (888) 201-4563
   Fax: (518) 408-1157

2. New York City Long Term Care Ombudsman program
   11 Park Place, Suite 1110
   New York, New York 10007
   (212) 962-2720

Revised Date: 4/22/16

3. Residents who are mentally ill or who have developmental disabilities should contact:

The Justice Center
161 Delaware Ave, Delmar, NY 12054
or by phone: (855) 373-2122

The resident will remain in the facility, (except in cases of imminent danger), pending the appeal hearing decision, if the appeal request is made within 15 days of the date the resident received the discharge/transfer notice; The hearing may be held post-discharge if the appeal request is made after 15 days following the date of receipt of this notice.

I have received a copy and read the above document pertaining to the right to appeal the notice of transfer or discharge.
The staff has explained this document to me and I understand the contents, however, I also understand that if I have any questions or concerns relative to this notice, that the staff will be glad to explain it again.

DATE_____ RESIDENT'S SIGNATURE_____

DESIGNATED REPRESENTATIVE C Francisone RELATIONSHIP Wife

RUTLAND NURSING HOME
585 Schenectady Avenue
Brooklyn, New York 11203
(718) 604 - 5221

Affix Label

PERSONAL BELONGINGS:

Since closet and drawer space is limited, please bring only those articles of clothing tha you will be wearing on a daily basis. We ask family members to store seasonal clothing We request that you have 10 changes of clothing articles. Comfortable and machine washable street clothing is the usual attire. We contract with a commercial laundry that provides routine laundry services for our residents. We cannot provide dry cleaning or hand-wash clothing. If necessary, hospital-type clothing will be provided to residents.

In order to assist us in protecting your valuables and personal belongings, please note the following:

1. **ALL CLOTHING AND PROPERTY MUST BE LABELED TO HELP PREVENT LOSS.** Rutland Nursing Home will ensure that all items are marked by RNH staff, as long as the article is given to the unit clerk or nurse to be marked.
2. **JEWELRY AND OTHER VALUABLES SHOULD REMAIN AT HOME.**
3. Please do not wrap your dentures in paper towels/tissues, leave them on your meal tray or place them in a container other than one designed for dentures, which is available at the Nurse's Station.

WE CANNOT BE RESPONSIBLE FOR THE LOSS OF MONEY, JEWELRY AND ELECTRONIC DEVICES THAT ARE NOT SECURELY STORED. Valuables should be sent home with family members and brought to the resident as special occasions arise. If valuables are kept at Rutland Nursing Home, they should be placed in the safe located in the Business Office. A receipt will be given to the resident or family member. The receipt will be required in order to reclaim these items. Upon request, a lock will be placed on an individual's drawer and/or closet.

RUTLAND NURSING HOME IS NOT RESPONSIBLE FOR THE LOSS OF VALUABLE ITEMS. If items are missing, an investigation will be conducted to determine if theft was indicated, however, RNH is not responsible for the reimbursement of these items.

Upon the reported loss of personal items, i.e. hearing aides, eyeglasses, personal clothing, dentures, Rutland Nursing Home will conduct an investigation. Reimbursement for these items will be dependent upon the result of the investigation.

C Francisque
Resident Signature

Witness/Social Worker LMSW

3/12/19
Date

KINGSBROOK JEWISH MEDICAL CENTER

RUTLAND NURSING HOME

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931

DATE: 3/12/2019

TO: Jean Francisque LTCM/WUBSHET, B. M CATHOLIC TW 1013B

RE: **RESIDENT PASS PRIVILEGES** ACCNT#: 1643155

This is to confirm that you have received the following information regarding Rutland Nursing Home Pass Privileges:

1. **Anytime that you leave your unit, you must notify the nursing staff that you are leaving and where you are going**

2. **If you wish to leave the facility grounds, you must obtain a 'Pass' from the Charge Nurse.**

3. **Prior to a 'Pass' being issued, the attending physician must authorize that you are eligible for a 'Pass'**

4. **When you receive the 'Pass' you must indicate where you are going, when you will be leaving and when you will return. You must indicate the address and phone number where you can be reached during the 'Pass' period.**

5. **The 'Pass' must be given to the Security Guard located in the DMRI lobby.**

6. **When you return to the facility, you must report to the Security Guard and then return immediately to your unit so that the staff know you have returned to the facility.**

7. **The possession, distribution and/or consumption of alcohol and/or illegal substances are strictly forbidden at Rutland Nursing Home.**

8. **Failure to comply with these regulations will result in the denial of 'Pass privileges.**

9. **Leaving the facility without an approved 'Pass' will be considered as "Leaving Against Medical Advice" and result in your immediate discharge form Rutland Nursing Home**

10. **I_____ release Rutland Nursing Home from all responsibilities, including my care and safety while I am Out On Pass.**

Resident's Signature O'Francisque

Witnessed By: _____

Social Worker

KINGSBROOK
JEWISH MEDICAL CENTER

Rutland Nursing Home
Interdisciplinary Resident and Family Education Record

Resident Identification

Barriers to Learning Identified

❑ **NONE** ❑Impaired Memory ❑Culture ❑Religion ❑Language Barrier
❑Limited Cognition ❑Limited Hearing ❑Limited Vision ❑Emotional Barrier ❑Unable to Read
❑Other

Learning Preference: _____ **Ready to learn?** Yes No

Legend

Learner		Teaching Method		Evaluation of Learning
1. Resident	4. Child(ren)	1. Discussion	4. Video	1. Verbalized Understanding
2. Spouse	5. Sibling	2. Demonstration	5. Communication Board	2. Return Demonstration
3. Parent	6. Other	3. Handout	6. Other	3. Needs Reinforcement
				4. Unable to Teach

Date/ Initials	TOPICS	Learner	Teaching Method	Evaluation of Learning	Comments
	Disease Process/Condition/Medication ❑MI ❑Pneumonia ❑ CHF ❑Post Op Care ❑DM ❑ CAD ❑ Medication _____ Other (Specify):_____				
	Disease Process/Condition/Medication ❑COPD ❑Pneumonia ❑Bronchitis ❑Asthma ❑Ventilator Support ❑ Medication _____ Other (Specify):_____				
	Disease Process/Condition/Medication ❑Angina ❑Hypertension ❑Stroke ❑Arrhythmia ❑GI Obstruction ❑ Medication _____ Other (Specify):_____				
	Disease Process/Condition/Medication ❑Acute Renal Failure ❑UTI ❑Chronic Renal Failure ❑Cellulitis ❑ Medication _____ Other (Specify):_____				
	Disease Process/Condition/Medication ❑Alzheimer's Disease ❑Dementia ❑Depression ❑ Medication _____ Other (Specify):_____				

Date/ Initials	TOPICS	Learner	Teaching Method	Evaluation of Learning	Comments
	Heart Failure Instructions ❑ Weight monitoring ❑ Discharge Plan ❑ Activity ❑ Worsening Symptoms ❑Diet (see **Nutrition**) ❑ No Smoking				
	❑**Warfarin (Coumadin) Instructions** ●Indication ●Follow-up monitoring ●Drug interactions ●Adverse drug events ●Compliance ●Diet (**See Nutrition**) ●Handout given				
	❑**Enoxaparin (Lovenox) Instructions** ●Indication ●Follow-up ●Monitoring ●Drug interactions ●Adverse drug events ●Handout given ●Self-administration				
	Medication Specify:____________ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:____________ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:____________ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:____________ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:____________ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:____________ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Pain ❑Reporting ❑Management ❑ Medication ____________				
	Activity ❑As Tolerated ❑Other:____________				
	Smoking Cessation ❑Policy ❑ Cessation ❑ NY State Quitline **1-866-697-8487** ❑ KJMC Clinic **718-604-5000 ext 5388**				
	Nutrition ❑Fluid Restricted to______L/day ❑Carbohydrate Control ❑Renal ❑Low Sodium ❑Low Fat/Low Cholest. ❑Read Food Labels ❑Food/Drug Interactions ❑Warfarin (Coumadin) ❑Other:____________				

Date/ Initials	TOPICS	Learner	Teaching Method	Evaluation of Learning	Comments
	Rehabilitation Medicine ❑PT ❑OT ❑Speech Therapy ____________ ❑Audiology ❑Neuropsychology ❑Other: ____________				
	Social Work **1. Discharge Alert** ❑LT Goal ❑ST Goal ❑Home ❑ SNF ❑NH Hospice ❑Other: ____________ **2. Advance Directives** ❑DNR ❑DNI ❑HCP ❑Living Will **3. OOP Policy** ❑Reviewed ❑Letter Given ❑NA				
	Resident Safety ❑Fire Safety Education ❑Fall Prevention ❑Infection Control • Disposal of food products • Proper food storage • Hand washing protocol ❑Medication: ____________				
	Long Term Discharge Plan ❑Specify: ____________				
	Financial ❑Specify: ____________				
	Other ❑Specify: ____________				
	Other ❑Specify: ____________				
	Resident Responsibility ❑Admission Package given to resident/family member ❑Closet key given with instruction				
3/7/19	**Wound Care** ☑Specify: Lt heel DTI	2,4	1	1	Res family made aware.
	Immunizations ❑Specify: ____________				
	Tests/Procedures ❑Specify: ____________				
	Tests/Procedures ❑Specify: ____________				
	Community Service/Referrals ❑Specify: ____________				
	Other Topic:				
	Other Topic:				

Initials	Patient Educator (Print Name)	Signature	Department/Service

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
-- M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

RUTLAND NURSING HOME
Baseline Care Plan Page 1
Admission Date: 3/6/19 **Allergies:** NKA **Code Status:** ____ DNR ____

Initial Goals

- ☐ Discharge to Community
- ☐ Remain in LTC
- ☒ STR
- ☐ Other: ________

Resident Information
Resident preferred name: Mr Francisque
Representative name and contact number: Carmelle Francisque

Cognition
- ☐ Alert/cognitively intact
- ☑ Confused
- ☐ Elopement Risk
- ☐ Intervention: ________

Communication
- ☑ Verbal (intermittent)
- ☐ Non Verbal
- ☐ Preferred language or method of communication: English/Creole

Vision
- ☐ Vision adequate
- ☐ Vision impaired: ________
- ☐ Appliance: ________

Hearing
- ☒ Hearing adequate
- ☐ Hearing impaired: ________
- ☐ Appliance: ________

Communication, hearing or vision risk
- ☐ Interventions: Refer to Speech

Dietary Orders

- ☐ Regular Diet
- ☐ Other: ________
- ☐ IV fluids: ________
- ☐ TPN/PPN: ________
- ☒ Tube fed: glucerna 1.2 1/80
Residents' dietary preferences ________

Dietary risks
- ☐ Risk for weight loss
- ☐ Risk for swallowing problems
- ☐ Risk for chewing problems
- ☑ Other: Has Lt heel DTI

Resident's dietary goal
- ☒ Maintain current weight
- ☐ Prevent weight loss
- ☒ Heal DU
- ☐ ________

Dietary interventions
- ☐ Lunch in dining room
- ☐ Prefers to eat in room
- ☐ Dentures or partials
- ☐ Specialty devices: ________
- ☒ Other: Ree Profom 30ml BID

Oral
- ☐ Full upper ☐ full lower
- ☐ Partial upper ☐ Partial lower

Therapy Services

- ☑ PT: 5-7 days/wk
- ☑ OT: 3-7 days/4 wks.
- ☑ SLP: Speech/swallow evaluate. recommended → 3-5x/4weeks
- ☐ Restorative
- ☐ Program(s): ________

Residents' functional goals
- ☐ Maintain current functional status
- ☐ Improvement

Decline: ↓ functional status.

Functional interventions
- ☑ Transfer/Ambulation
- ☑ ADL/selfcare retraining

[redacted]

Safety
- ☐ History of falls; ________
- ☐ History of fall-related injury: ________

Social Services

- ☐ Mental health needs: none
- ☐ Behavior concerns: – none noted, not identified
- ☐ PASARR level II recommendation*: N/A
- ☐ Depression screening: None

Able to recognize need for placement in nursing home: does not seem to recognize need aphasia – non verbal

Resident psychosocial/psychosocial interventions
- ☐ Behavior interventions
- ☐ Orientation
- ☐ Adjustment
- ☐ Encouragement
- ☐ Attend discharge E...

*A resident admitted with mental illness or intellectual disability requires level 2 screening

RUTLAND NURSING HOME

Baseline Care Plan Page 2

Bed Mobility	☐ Independent ☑ Assist of 2	☐ Setup ☐ Total dependence	☐ Assist of 1 ☐ N/A	**Locomotion**	☐ Independent ☐ Assist of 2	☐ Setup ☑ Total dependence	☑ Assist of 1 ☐ N/A
Transfer	☐ Independent ☑ Assist of 2	☐ Setup ☐ Total dependence	☐ Assist of 1 ☐ N/A	**Eating**	☐ Independent ☐ Assist of 2	☐ Setup ☑ Total dependence	☐ Assist of 1 ☐ N/A
Walking	☐ Independent ☐ Assist of 2	☐ Setup ☑ Total dependence	☐ Assist of 1 ☐ N/A	**Personal Hygiene**	☐ Independent ☐ Assist of 2	☐ Setup ☑ Total dependence	☐ Assist of 1 ☐ N/A
Toileting	☐ Independent ☑ Assist of 2	☐ Setup ☐ Total dependence	☐ Assist of 1 ☐ N/A	**Bathing**	☐ Independent ☐ Assist of 2	☐ Setup ☑ Total dependence	☑ Assist of 1 ☐ N/A
Equipment	☑ Wheelchair ☐ cane/ walker type: _____ ☐ Sit to stand ☐ Side rails for enabler L or R ☑ Hydraulic Lift ☐ ☐ _____ ☐ _____ ☐ _____ ☐ _____			**Comments (assistive devices) (Mittens and reason):**			

☐ Ventilator ☐ Tracheostormy ☐ Suction ☐ CPAP ☐ Bipap
☑ Oxygen Type 2L/min ☐ Suctioning

☐ IV Medications:
Type/ location/ dressing change: _____
_____
_____

☐ Isolation: _____
☐ Dialysis
☐ Radiation
☐ Chemotherapy
☐ Other
☐ other

Bowel
☐ Continent
☑ Incontinent
☐ Appliance_____

Bladder
☐ Continent has Depends
☑ Incontinent
☐ Appliance_____

Bowel and bladder risk
☐ Risk for incontinence

Bowel and bladder goal
☐ _____
☐ toilet schedule

Skin
~~☐ Intact~~
☑ Pressure ulcers: Explain
Lt Heel DTI
_____
_____

☐ Skin break risk _____
☑ Resident's skin integrity goal To maintain skin integrity

☑ Turn and position ☑ Specialty mattress ☐ Cushions

Treatments:

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FRANCISQUE ,JEAN
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RUTLAND NURSING HOME
Baseline Care Plan Page 3

ACCNT#: 1643155

☑ Current medications list and reason

☐ Prednisone	☑ H.TN
☐ Pantoprazole	☐ Coreg
☐ Insulin	☐ Diabetes
☐ Nystatin	☐ Cytomegalovirus
☐	☐

☑ Insulin Blood glucose checks Diabetic
☐ Anticoagulant ☐ Lab monitoring s/s of bleeding
☐ Antibiotics & reason
☐ Psychotropic & Reason
☐ Side effects
☐ Pain reason

Discharge Plans
☑ Not occurring at present
☐ Resident to return to
☐ Equipment needed ☐ Caregiver

☐ Resident or caregiver education needed for discharge:

Outside coordination
☐ Dialysis
☐ Meal preparations
☐ Home care ☐ N/A

☐
☐ Risk
☐ Intervention

☐
☐ Risk
☐ Intervention

Resident's life history prior to nursing home Resident lived alone
Resident's daily routine and preferences Resident enjoys traveling
Resident's cultural/ethnic/religious preferences Catholic

Barriers to resident's discharge
☐ none identified
☐

☐ Hospice information

Other:

Signatures of Interdisciplinary team members Contributing to Baseline Care Plan

Nursing: RN
Recreation:
Speech:
Social Work: 3/7/19 LMSW
Physical Therapy:
Other:
Dietary:
Occupational Therapy:
Other:

Written Summary of Baseline Care Plan

Completion Dates

Admission date: _____	Baseline care plan completion date: _____	Date reviewed with resident/representative: _____
Nurse: _____ RN	Resident signature: _____	Representative signature: _____

Update to Baseline Care Plan

Date: _____ _____ Signature: _____

Date: _____ _____ Signature: _____

Date: _____ _____ Signature: _____

Date: _____ _____ Signature: _____

Date: _____ _____ Signature: _____

Date reviewed with resident/representative: _____ Resident/Representative signature: _____

☐ Baseline care plan discontinued due to completion of comprehensive care plan Signature: _____ Date: _____

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

RUTLAND NURSING HOME
Baseline Care Plan Page 4

Written Summary of Baseline Care Plan

71 y/o Male admission Alert Oriented x1-person responding minimally to verbal stimuli, incontinent of B function. Texas Catheter in place draining clear yellow urine. PEG in place c Glucerna via feeds. At risk for aspiration 2/2 Stroke & dysphagia. Skin clean & intact. Require assist x1 c ADL's & personal. Spouse provided history as resident is poor historian. Goal is to return to community after therapy as per spouse. Denied pain/discomfort, will continue to monitor

Completion Dates

Admission date: 3/6/19 Nurse: Joseph RN	Baseline care plan completion date: 3/6/19 Resident signature:	Date reviewed with resident/representative: 3/6/19 Representative signature: X CARMELLE FRANCISQUE

Update to Baseline Care Plan

Date: ______ Signature: ______

Date: ______ Signature: ______

Date: ______ Signature: ______

Date: ______ Signature: ______

Date: ______ Signature: ______

Date reviewed with resident/representative: ______ Resident/Representative signature: ______

☐ Baseline care plan discontinued due to completion of comprehensive care plan Signature: ______ Date: ______

RUTLAND NURSING HOME
Baseline Care Plan Page 3

☑ Current medications list and reason

☐ Aspirin / stroke	☐
☐ insulin / DM	☐
☐ metoprolol / HTN	☐
☐ Ranitidine / Gastritis	☐
☐	☐

Other conditions:
☐ _____
☐ Risk _____
☐ Intervention _____

☐ _____
☐ Risk _____
☐ Intervention _____

☑ Insulin Blood glucose checks _____
☑ Anticoagulant ☐ Lab monitoring s/s of bleeding aspirin EC
☐ Antibiotics & reason _____
☐ Psychotropic & Reason _____
☐ Side effects _____
☐ Pain reason _____

Resident's life history prior to nursing home lived in _____
Resident's daily routine and preferences _____
_____
Resident's cultural/ethnic/religious preferences _____
_____

Discharge Plans
☑ Not occurring at present
☐ Resident to return to _____
☐ Equipment needed _____ ☐ Caregiver

Barriers to resident's discharge
☐ _____
☐ _____

☐ Resident or caregiver education needed for discharge:

☐ Hospice information

Outside coordination
☐ Dialysis
☐ Meal preparations
☐ Home care

Other:

Signatures of Interdisciplinary team members Contributing to Baseline Care Plan

_____ _____ _____
_____ _____ _____
_____ _____ _____

KINGSBROOK
JEWISH MEDICAL CENTER

3/2019

FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
09/16/1947 M CATHOLIC TW 1013B
LTCM/WUBSHET, B.

ACCNT#: 1643155

Resident Identification

Rutland Nursing Home
Interdisciplinary Resident and Family Education Record

Barriers to Learning Identified

☐ **NONE** ☐Impaired Memory ☐Culture ☐Religion ☐Language Barrier
☐Limited Cognition ☐Limited Hearing ☐Limited Vision ☐Emotional Barrier ☐Unable to Read
☐Other

Learning Preference: _____ **Ready to learn?** Yes No

Legend	Learner	Teaching Method	Evaluation of Learning
	1. Resident 4. Child(ren) 2. Spouse 5. Sibling 3. Parent 6. Other	1. Discussion 4. Video 2. Demonstration 5. Communication Board 3. Handout 6. Other	1. Verbalized Understanding 2. Return Demonstration 3. Needs Reinforcement 4. Unable to Teach

Date/ Initials	TOPICS	Learner	Teaching Method	Evaluation of Learning	Comments
	Disease Process/Condition/Medication ☐MI ☐Pneumonia ☐ CHF ☐Post Op Care ☐DM ☐ CAD ☐ Medication _____ Other (Specify):_____				
	Disease Process/Condition/Medication ☐COPD ☐Pneumonia ☐Bronchitis ☐Asthma ☐Ventilator Support ☐ Medication _____ Other (Specify):_____				
	Disease Process/Condition/Medication ☐Angina ☐Hypertension ☐Stroke ☐Arrhythmia ☐GI Obstruction ☐ Medication _____ Other (Specify):_____				
	Disease Process/Condition/Medication ☐Acute Renal Failure ☐UTI ☐Chronic Renal Failure ☐Cellulitis ☐ Medication _____ Other (Specify):_____				
	Disease Process/Condition/Medication ☐Alzheimer's Disease ☐Dementia ☐Depression ☐ Medication _____ Other (Specify):_____				

Date/ Initials	TOPICS	Learner	Teaching Method	Evaluation of Learning	Comments
	Heart Failure Instructions ❑ Weight monitoring ❑ Discharge Plan ❑ Activity ❑ Worsening Symptoms ❑Diet (see **Nutrition**) ❑ No Smoking				
	❑**Warfarin (Coumadin) Instructions** ●Indication ●Follow-up monitoring ●Drug interactions ●Adverse drug events ●Compliance ●Diet (**See Nutrition**) ●Handout given				
	❑**Enoxaparin (Lovenox) Instructions** ●Indication ●Follow-up ●Monitoring ●Drug interactions ●Adverse drug events ●Handout given ●Self-administration				
	Medication Specify:______ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:______ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:______ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:______ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:______ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Medication Specify:______ ❑Dose ❑Frequency ❑Route ❑Drug Interactions ❑Precautions ❑Adverse Drug Events ❑Monitoring				
	Pain ❑Reporting ❑Management ❑ Medication ______				
	Activity ❑As Tolerated ❑Other:______				
	Smoking Cessation ❑Policy ❑ Cessation ❑ NY State Quitline **1-866-697-8487** ❑ KJMC Clinic **718-604-5000 ext 5388**				
3/9/15	**Nutrition** ❑Fluid Restricted to______L/day ❑Carbohydrate Control ❑Renal ❑Low Sodium ❑Low Fat/Low Cholest. ❑Read Food Labels ❑Food/Drug Interactions ❑Warfarin (Coumadin) ☒Other: ___ CTF / Lt heel DTI	1	1	4	

Date/ Initials	TOPICS	Learner	Teaching Method	Evaluation of Learning	Comments
	Rehabilitation Medicine ❑PT ❑OT ❑Speech Therapy _____ ❑Audiology ❑Neuropsychology ❑Other:_____				
	Social Work **1. Discharge Alert** ❑LT Goal ❑ST Goal ❑Home ❑ SNF ❑NH Hospice ❑Other:_____ **2. Advance Directives** ❑DNR ❑DNI ❑HCP ❑Living Will **3. OOP Policy** ❑Reviewed ❑Letter Given ❑NA				
	Resident Safety ❑Fire Safety Education ❑Fall Prevention ❑Infection Control • Disposal of food products • Proper food storage • Hand washing protocol ❑Medication:_____				
	Long Term Discharge Plan ❑Specify:_____				
	Financial ❑Specify:_____				
	Other ❑Specify:_____				
	Other ❑Specify:_____				
	Resident Responsibility ❑Admission Package given to resident/family member ❑Closet key given with instruction				
	Wound Care ❑Specify:_____				
	Immunizations ❑Specify:_____				
	Tests/Procedures ❑Specify:_____				
	Tests/Procedures ❑Specify:_____				
	Community Service/Referrals ❑Specify:_____				
	Other Topic:				
	Other Topic:				

Initials	Patient Educator (Print Name)	Signature	Department/Service
MA	Milena Agnew		FNS

KINGSBROOK
JEWISH MEDICAL CENTER

www.kingsbrook.org

Rutland Nursing Home

RNH 0370519 03/06/19
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Fall/Function Risk Evaluation

Complete on admission quarterly, when there is a change in resident status.

Write each score on the column dates as corresponding risk factors are identified.

Risk Factors	Score	Dates of Risk Evaluation						
		3/6/19						
Age 65 years or older	2	2						
History of falls (6 months to 1 year) ★	15							
Unsteady Gait/Balance Problem ★	15	15						
Vertigo	3							
Osteoporosis	2							
Seizure Disorders	3							
Weakness/Multiple Myeloma ★	2	2						
Degenerative Joint Disease	2							
Paresis/Paralysis ★	3							
Hearing Impairment	2							
Sight Impairment	3							
Impaired Mental Status/Confused/Disoriented	15	15						
Drugs that have a diuretic effect	3							
Drugs that suppress thought processes and create a hypotensive effect I.e.: narcotics, sedatives, hypnotics, tranquilizers, antidepressants, antihypertensives.	6 (1 med) 7 (2 meds) 8 (3 meds) 9 (4 meds)	1						
Drugs that increase GI motility I.e.: laxatives	3							
Amputee Single above knee ★	7							
Single below knee ★	4							
Double above knee ★	9							
Double below knee ★	7							
Assistive Device Wheelchair	4	4						
Crutches	4							
Cane	4							
Walker	4							
Other	4							
Impaired ADL	4	4						
Total Score		43						
Write sum of scores in the boxes								
Nurse Initials								

Implement Fall Prevention Protocol (see back of form) for a score greater than 4
Responses with ★ require discussion for Rehab referral with MD documented in the PROGRESS notes.

Printed Name/Title	Signature	Initials
Nadine Joseph-Ku	Joseph-Ku	NJ

KINGSBROOK JEWISH MEDICAL CENTER
RUTLAND NURSING HOME

STANDARD OF CARE - FALLS

STATEMENT: **All residents admitted to Rutland Nursing Home will be assessed within 24 hours for risk for falls. They will also be evaluated quarterly, when there is a significant change in resident's condition, in order to prevent/reduce falls and injuries.**

Add APPROPRIATE interventions to the resident's care plan:

- ☐ **Resident to be evaluated by PT/OT post falls.**
- ☐ **Evaluate the resident's level of cognition.**
- ☐ **Orient resident to environment on admission and as necessary.**
- ☐ **Resident will wear comfortable and appropriate footwear; recommended use of non-skid slippers or shoes when ambulating.**
- ☐ **Inspect resident's feet daily for presence of ulcers/callouses**
- ☐ **Keep resident's bed at lowest position.**
- ☐ **Place call light within easy reach of resident.**
- ☐ **Keep personal belongings within easy reach of resident.**
- ☐ **Determine level of ADL care required and provide appropriate care.**
- ☐ **Toilet resident every two hours if the resident has the ability to be toileted.**
- ☐ **MD to review for psychotropic medications, diuretics, anti-hypertensive medications and adjust dosage appropriately to meet resident's needs.**
- ☐ **Encourage resident to use call light and ask for assistance.**
- ☐ **Anticipate resident's needs.**
- ☐ **Instruct resident to use handrails in bathrooms, showers, hallways.**
- ☐ **Assist resident with transfer when indicated.**
- ☐ **Teach resident safe transfer techniques.**
- ☐ **Ensure resident has a yellow dot on ID bracelet indicating high risk for falls.**

RUTLAND NU' ING HOME

Comprehensive Care Plan Attendance Form

RNH 0370519 03/06/19
FRANCISQUE ,JEAN
FRANCISQUE ,GLADYS
917-325-1931
M CATHOLIC TW 1013B
LTCM/WUBSHET, B.
ACCNT#: 1643155

ATTENDEES	Date: 3/21/19	Date:	Date:	
	Reason for CCP ☒ Initial ☐ RE: Admission ☐ Medicare ☐ Significant Change ☐ Annual ☐ Quarterly ☐ Health Care Proxy ☐ DNR ☐ Other ☐ Living Will ☐ Modification Self Administration	Reason for CCP ☐ Initial ☐ RE: Admission ☐ Medicare ☐ Significant Change ☐ Annual ☐ Quarterly ☐ Health Care Proxy ☐ DNR ☐ Other ☐ Living Will ☐ Modification Self Administration	☐ Initial ☐ RE: Admission ☐ Medicare ☐ Significant Change ☐ Annual ☐ Quarterly ☐ Health Care Proxy ☐ DNR ☐ Other ☐ Living Will ☐ Modification Self Administration	☐ Initial ☐ RE: Admission ☐ Medicare ☐ Significant Change ☐ Annual ☐ Quarterly ☐ Health Care Proxy ☐ DNR ☐ Other ☐ Living Will ☐ Modification Self Administration
	SIGNATURES	SIGNATURES	SIGNATURES	SIGNATURES
RESIDENT				
FAMILY / RESIDENT REP	Francisque, Katia F.			
NURSING: RN / LPN				
CNA				
SOCIAL WORKER				
FOOD & NUTRITION				
RECREATIONAL THERAPY				
REHAB (PT/OT)				
SPEECH THERAPY				
PHYSICIAN / NP				
OTHER				
CCP REVIEWED AND APPROVED BY PHYSICIAN	PHYSICIAN'S SIGNATURE & DATE	PHYSICIAN'S SIGNATURE & DATE	PHYSICIAN'S SIGNATURE & DATE	PHYSICIAN'S SIGNATURE & DATE
CCP REVIEWED WITH RESIDENT FAMILY OR RESIDENT REPRESENTATIVE	NAME OF FAMILY / RESIDENT REP. SOCIAL WORKER SIGNATURE & DATE	NAME OF FAMILY / RESIDENT REP. SOCIAL WORKER SIGNATURE & DATE	NAME OF FAMILY / RESIDENT REP. SOCIAL WORKER SIGNATURE & DATE	NAME OF FAMILY / RESIDENT REP. SOCIAL WORKER SIGNATURE & DATE

jmf - 5S / (UPDATED) AUGUST 2012

Care Plan	Implemented	Resolved	Care Plan	Implemented	Resolved
1. Falls/Injury			28. Self Care Deficit-Locomotion/Transfer		
2. Physical Restraint Use			29. Ineffective Breathing/AirwayClearance		
3. Psychotropic Drug Use			30. Decreased/Increased Cardiac Output		
4. Pain			31. Altered Tissue Perfusion		
5. Sleep Pattern Altered			32. Sensory-Preceptual Alteration-Visual		
6. Non-Compliance			33. Sensory- Preceptual Alteration-Auditory		
7. Maintaining Wellness/Independence			34. Dementia-Cognitive Loss		
8. Knowledge Deficit			35. Delirium-Confusional State		
9. Discharge Planning			36. Impaired Communication		
10. Below Ideal Body Weight/Weight Loss			37. Impaired Social Interaction and/or Social Isolation		
11. Above Ideal Body Weight/Weight Gain			38. Impaired Adjustment		
12. Tube Feeding			39. Problem Behavior		
13. Therapeutic Diet			40. Altered Feelings/Mood State		
14. Diabetes Mellitus			41. Dysfunctional Family Coping/Interaction		
15. Fluid Volume (Excess-Deficit)					
16. Impaired Skin Integrity					
17. Impaired Oral/Dental Condition					
18. Infection					
19. Bowel/Bladder Incontinence					
20. Impaired Bowel/Bladder Elimination (Ostomy - Indwelling Urinary Catheter)					
21. Diarrhea					
22. Constipation					
23. Self Care Deficit-Total					
24. Self Care Deficit-Feeding					
25. Self Care Deficit-Bathing/Hygiene					
26. Self Care Deficit-Dressing/Grooming					
27. Self Care Deficit-Toileting					

RESIDENT PROBLEM

Definition: Elevated glucose levels beyond normal for the resident.

Evidenced by:

- Elevated blood glucose levels (circled)
- Physical symptoms of hyperglycemia/ hypoglycemia

Related to:

- Hormonal/glandular dysfunction (circled)
- Non-compliance with diet
- Overweight
- Other ______

Secondary to:

- Insulin dependent diabetes (circled)
- Non-insulin dependent diabetes

EXPECTED OUTCOME

Resident will:

1. (circled) Demonstrate a blood glucose level within normal limits for the resident (specify): ______
2. (circled) Be free of observable signs/symptoms of hypoglycemia/ hyperglycemia.
3. Maintain/achieve ideal body weight/usual weight of ______
4. Attain and maintain optimal nutritional status.
5. Achieve individual acceptance and compliance to diabetic diet.
6. Other ______

OUTCOME EVALUATION

No.	Date	Y	N	D.C.
1	6/			
2	/19			

INTERVENTIONS / RESPONSIBILITIES

INTERVENTIONS	MED	NSG	SW	TR	DT	ADM	OTH	DATE IMP.	DATE DC
• (circled) Monitor blood glucose levels on a regular basis	✓	✓			✓			3/7/19	
• (circled) Monitor weight regularly	✓	✓			✓				
• (circled) Monitor for observable signs/symptoms of hyperglycemia/hypoglycemia	✓	✓			✓				
• (circled) Monitor labs	✓	✓			✓				
• (circled) Implement diet as ordered by MD		✓			✓				
• (circled) Provide regular podiatry care as ordered by MD		✓							
• (circled) Provide hygiene/foot care on a regular basis		✓							
• (circled) Administer medications as ordered by MD ↳ Insulin — Oral hypoglycemic agents		✓							
• Plan and implement nutrition/diet teaching program for resident/family/significant other.									
• Provide positive reinforcement for compliant behavior									
• (circled) Provide individual/family nutritional counseling		✓	✓	✓	✓			3/7/19	
• Develop individual diet plan to meet psycho/emotional needs to promote diet compliance									
• Coordinate with Activities and other disciplines regarding dietary restrictions									

✓ DIABETES MELLITUS
☐ ACTUAL
☐ POTENTIAL

Name: [illegible] S
Room #: 1013 B
Medical Record Number: ______
Initial Care Plan Date: 3/7/19

DIABETES MELLITUS
☐ ACTUAL
☐ POTENTIAL

ID | RESIDENT PROBLEM | EXPECTED OUTCOME | OUTCOME EVALUATION | INTERVENTIONS | RESPONSIBILITIES | DATE INIT. | DATE DC

Page 2 of 2

Comprehensive Care Pla

RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: Init	Date	Addr'd Y	Addr'd N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE D/C
Definition: A state in which resident receives some or all of fluids and/or nutrients via a tube to the gastrointestinal tract. **Evidenced by:** • Feeding tube present **Related to:** • Coma • Cognitive impairment • Impaired swallowing • Esophageal pathology • Severe anorexia • Other_____ **Secondary to:** • Medical diagnosis/problem • CVA • Trauma	**Resident will:** 1. Tolerate tube feeding. 2. Be free of signs/ symptoms of complications of tube feeding. 3. Maintain weight of _____. 4. Gain weight of _____ pounds by next assessment. 5. Be successfully weaned from tube feeding. 6. Maintain skin integrity. 7. Be adequately hydrated as evidenced by normal lab values for the resident and signs and symptoms of adequate hydration. 8. Receive adequate nutrition via tube feeding. 9. Other_____						• Monitor weight regularly	✓	✓			✓			3/7/19	
							• Monitor/report to MD signs/ symptoms of complications of tube feeding	✓	✓						3/7/19	
							• Administer tube feeding/fluid intake as ordered by MD	✓	✓							
							• Provide nasal/oral/stoma care as per nursing policy and procedure	✓	✓							
							• Elevate head of bed 30° - 45° during feeding		✓							
							• Monitor I&O		✓			✓				
							• Refer to speech therapist for evaluation of swallowing ability and implement recommendations as indicated by MD		✓			✓				
							• Plan and implement a program for weaning resident from the tube feeding		✓			✓			✓	
							• Provide positive reinforcement and emotional support									
							• Coordinate dysphagia program									
							• Monitor p.o. tolerance/intake									
							• Adjust or change tube feeding formula									
							• Other_____									

TUBE FEEDING
☑ **ACTUAL**
☐ **POTENTIAL**

Name: Francis Bue J
Room #: 1013 B
Medical Record Number:
Initial Care Plan Date: 3/7/19

#12

RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No	Date	Ach'd Y	Ach'd N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE DC
Definition: Infrequent excretion of hard dry stools or inadequate bowel elimination. Evidenced by: • Urinary incontinence • Toileting plan • Enemas, irrigations used • Constipation • Fecal impaction • Oozing of stool • Infrequent stools • Hard/dry stool • Complaints of rectal pressure • Need to strain on defecation • Poor appetite • Nausea • Decreased bowel sounds • Other_____ Related to: • Chemotherapy • Immobility • Diet • Drugs • Poor fluid intake • Impaired neuro-muscular systems • Psychosocial status • Aging • Other_____	Resident will: 1. Establish a regular pattern of bowel function. 2. Defecate without straining/discomfort. 3. Other_____	1	3/6/19				• Monitor frequency/ consistency of stool		✓						3/7/19	
		2	3/6/19				• Obtain GI consult			✓					3/7/19	
							• Monitor for impaction		✓						3/7/19	
							• Manually disimpact as necessary									
							• Plan and implement a bowel training program specific to resident's needs									
							• Plan and implement toileting schedule									
							• Provide high fiber foods within diet ordered by MD									
							• Encourage fluid intake via GT		✓			✓			3/7/19	
							• Administer medications as ordered by MD									
							• Toilet immediately when requested									
							• Provide privacy									
							• Administer local ointments/ lubricants to anus/rectum as ordered by MD									
							• Utilize suppositories and/or digital stimulation									
							• Adminster enemas as ordered by MD		✓						3/7/19	
							• Encourage to be as active as possible given specific limitations		✓						3/7/19	

CONSTIPATION
ACTUAL
POTENTIAL

Name: Francisque, J
Room #:
Medical Record Number:
Initial Care Plan Date: 3/7/19

CONSTIPATION
] ACTUAL
] POTENTIAL

TE LE TED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No	Date	Ad'd Y	Ad'd N-	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE DC
	Secondary to: • Medical diagnosis/problem _____ _____ _____ _____ _____ • CVA • Trauma							• Initiate further medical diagnostic evaluation where indicated • Other_____ _____ _____									

Comprehensive Care Plan

DATE PLE-TED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No	Date	Ach'd Y	Ach'd N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE DC
3/7/19	Definition: A reduction/ increase in the amount of blood pumped by the heart resulting in altered cardiac function or an imbalance between oxygen uptake and carbon dioxide elimination in the lung. Evidenced by: • Arrythmia • Tires noticeably • Shortness of breath-dyspnea Abnormal blood gas Confusion, restlessness • Chest pain • Activity intolerance • Syncope - fainting • Pulmonary edema • Cold, clammy skin • Oliguria, anuria • Jugular vein distention • Bradycardia • Tachycardia • Anxiety • Other Related to: • Mechanical problems of heart • Electrical problem of heart • Pulmonary disorder • Endocrine disorder • Alveolar - capillary membrane changes • Other	Resident will: 1. Maintain and/or regain a normal respiratory rate. 2. Maintain and/or regain normal cardiac output. 3. Have fewer episodes of shortness of breath. 4. Demonstrate a reduction in peripheral edema. 5. Other	1	4				• Provide medical management of underlying medical condition	✓	✓						3/7/19	
		2	4				• Monitor vital signs - frequency: Qshift		✓						3/7/19	
		3	1				• Monitor blood work regularly		✓			✓				
		4	1				• Assess O_2 needs regularly	✓	✓							
							• Monitor I & O									
							• Monitor weight - frequency: WKly x 4	✓	✓			✓				
							• Order/provide O_2									
							• Order/provide humidification treatment									
							• Order/provide medications	✓	✓							
							• Position to encourage increased/ comfortable breathing (e.g. High-Fowlers)									
							• Pace care to conserve energy									
							• Order/provide diet - (specify): TF	✓	✓			✓				
							• Elevate legs								✓	

DECREASED/INCREASED CARDIAC OUTPUT;
IMPAIRED GAS EXCHANGE
☑ ACTUAL
☐ POTENTIAL

Name: Francisque, J
Room #:
Medical Record Number:
Initial Care Plan Date: 3/7/19

DECREASED/INCREASED CARDIAC OUTPUT;
IMPAIRED GAS EXCHANGE
☐ ACTUAL
☐ POTENTIAL

ATE PLE-NTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No	Date	Ach'd Y	Ach'd N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE DC
	Secondary to: • Medical diagnosis/problem • COPD • Aging process • CHF • Hypertension • DM • Hypo/hyperthyroidism • Asthma • Other CVA							• Teach O_2 conservation techniques • Order/apply anti-emboli stockings • Provide mouth care - frequency: ___ • Encourage to avoid smoking • Provide respiratory treatment - (specify):___ • Order/provide TR within limitations • Other___		✓						3/11/15	

Comprehensive Care Plan

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No.	Date	Addl Y	Addl N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE DC
3/7/19	**Definition:** Presence of skin breakdown or at high risk for skin breakdown. **Evidenced by:** Stasis ulcer Pressure ulcer SDTI Stage: DS 1, 4 Heel • History of pressure ulcers • Abrasions/bruises • Burns • Surgical wounds • Lacerations • Open lesions • Tracheostomy • Preventive/protective skin care • Turning and positioning program • Pressure relief devices in use • Skin tear • Gangrene **High Risk/Related to:** • Joint pain • Pain: _____ • Radiation therapy • Coma • Amputation • Bedfast • Hemiplegia/hemiparesis • Quadriplegia • Lack of voluntary movement • Feeding tube • Skin desensitized to pain/pressure, discomfort • Edema • Incontinence of bowels • Decline in ADL • Incontinent of urine • External urinary catheter • Indwelling urinary catheter	**Resident will:** 1. Demonstrate healing/healed lesion. 2. Maintain intact skin integrity. 3. Be free of infection. 4. Avoid prolonged pressure to skin. 5. Demonstrate weight shifting. 6. Verbalize knowledge of interventions that minimize pressure/skin breakdowns. 7. Demonstrate good skin care technique. 8. Other _____	1	6/19				• Assess skin every shift		✓						3/7/19	
			3	7/19				• Assess risk factors on an ongoing basis	✓	✓						7/19	
								• Monitor lab values - report/treat abnormalities	✓	✓			✓				
								• Provide individualized pressure relief intervention as per Skin Integrity Protocol		✓							
								• Release restraints every two hours and provide activity as per order									
								• Turn and position every two hours and as required		✓							
								• Protect bony prominences								✓	
								• Elevate legs									
								• Implement ROM as per PT/OT/nursing orders		✓						3/7/19	
								• Provide diet as ordered		✓			✓			7/19	
								• Assist with feeding as needed									
								• Provide adequate calories and protein		✓			✓				
								• Vitamin C supplement			✓					✓	

IMPAIRED SKIN INTEGRITY
☑ ACTUAL
☑ POTENTIAL

Name: [illegible]
Room #: _____
Medical Record Number: _____
Initial Care Plan Date: 3/7/19

16. **IMPAIRED SKIN INTEGRITY**
☐ ACTUAL
☐ POTENTIAL

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION No	Date	Ach'd Y	Ach'd N	D/C	INTERVENTIONS	MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE DC
	High Risk/Related to: (cont'd) • Intermittent urinary catheter • Ostomy • Restraint use daily • Difficulty positioning due to spasticity/movement disorder/contractures/other • Impaired cognition • Resists ADL • Impaired hygiene • Drug therapy • Agitation • Fragile skin • Behavior problem • Debilitation • Terminal illness • Shearing • Nutritional impairment • Movement disorder • (circled) Impaired circulation • (circled) Other ~~Rt Hell DTI~~ 2.5 x 3.0 dark gray mushy							• Zinc supplement									
								• Protein supplement									
								• Encourage fluid intake									
								• (circled) Provide skin care as per Skin Integrity Protocol								3/7/19	
								• (circled) Provide wound care as ordered by MD									
								• Administer topical/oral meds as ordered by MD and monitor response regularly									
								• (circled) Provide gentle support when turning/positioning/transferring								3/7/19	
								• Provide care to stoma site									
								• Measure depth and circumference of the pressure ulcer at least weekly									
								• (circled) Document response to treatment on the Decubitus Record at least weekly								3/7/19	
								• (circled) Observe for signs of necrosis, infection, healing and refer to physician for further interventions								3/7/19	
								• Debride wound surgically/debriding agent as ordered by MD									
								• Evaluate for plastic surgery intervention									
								• (circled) Other Offload Heel on Pillow. Notify MD / resident's wife/daughter Re the plan	✓	✓	✓					3/7/19	

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No	Date	Ach'd Y	Ach'd N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REN	OTH	DATE IMP.	DATE D/C
3/7/19	**Definition:** Inability or impaired ability to communicate due to problems with hearing, understanding, use of language or ability to articulate words or sounds. **Evidenced by:** • Social isolation • Hearing aid used • Other receptive communication techniques used • Not understood by others • Does not understand others • Does not speak • Confusion - disorientation • Frustrated behavior • Does not engage in social/verbal interaction • Incoherent speech • Writes messages • Signs, gestures, sounds • Uses devices to communicate • Uses American sign language/Braille • Limited/no participation in activity programs • Other_____ **Related to:** • Ventilator dependent care • Tracheostomy • Coma • Non-English speaking • Impaired hearing • Impaired decision making • Chronic condition • Acute condition • Knowledge deficit	**Resident will:** 1. Communicate needs to staff. 2. Maintain present level of communication (specify): 3. Demonstrate understanding of received message. 4. Use alternate means to communicate (specify): 5. Speak/communicate more effectively (specify): 6. Engage in social/verbal interaction. 7. Have needs met. 8. Maintain dignity and increase self esteem. 9. Other_____	1 6 2	6/19 6/19 3/7/19				• Provide speech-language pathology/audiology services • Evaluate speech/ communication problem • Provide speech/hearing/ communication restorative/ maintenance rehabilitation therapy • Use augmentative communication (specify): • Recognize frustration provide support • Allow time to respond • Achieve resident's attention prior to speaking/ communicating • Encourage resident to engage in social interaction/ recreational activities • Speak slowly/clearly using simple words/sentences • Support self-esteem	✓	✓						3/7/19 3/7/19 3/7/19 3/7/19 3/7/19 3/7/19	

36. IMPAIRED COMMUNICATION
☐ ACTUAL
☐ POTENTIAL

Name: Francisque, J
Room #:
Medical Record Number:
Initial Care Plan Date: 3/7/19

36. IMPAIRED COMMUNICATION
☐ ACTUAL
☐ POTENTIAL

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION No	OUTCOME EVALUATION Date	OUTCOME EVALUATION Ach'd Y	OUTCOME EVALUATION Ach'd N	OUTCOME EVALUATION D/C	INTERVENTIONS	RESPONSIBILITIES MED	NSG	SW	TR	DT	RSH	OTH	DATE IMP.	DATE DC
	Related to: (continued) • Medications • Impaired speech production • Activity intolerance • Word finding problem • Confusion - disorientation • Other_____ _____ _____							• Encourage to practice and incorporate adaptive techniques into daily communication									
								• Encourage family to support and be involved with resident		✓	✓	✓				3/1/19	
								• Arrange for interpreter/alternate means for resident to communicate needs									
	Secondary to: • Alzheimer's Disease • Dementia • Parkinson's Disease • CVA • Infection • Depression • Delirium • Multiple Sclerosis • ALS • Head trauma • Laryngectomy • Cerebral palsy • Medical diagnosis/problem _____ _____ _____ _____ _____ _____							• Other_____ _____ _____									

...SING HOME Comprehensive C... Plan

DATE IMPLEMENTED: 3/7/19

RESIDENT PROBLEM

Definition: History of falls, or at risk for fall or injury.

Evidenced by:

- Fell in last 30 days
- Fell in last 31 to 180 days
- (circled) Hip or other fracture in last 30 days
- (circled) Presence of high risk factors
- Restraints
- Other________

Related to:

- Use of visual appliances
- Impaired memory
- Impaired vision
- Wandering
- Delirium/dementia
- Resists assistance with ADLs
- (circled) Admission/room change
- Relocation
- Coma
- (circled) Impaired balance
- Lack of voluntary movement
- Bedfast
- Hemiplegia/hemiparesis
- Quadriplegia
- Amputation
- Contractures
- Deterioration in ADL
- Dizziness/vertigo
- Joint pain
- Pain:________
- Psychotropic drug use
- Impaired decision making
- Impaired hearing
- Mood/withdrawal/ depression
- Incontinence
- Orthostatic hypotension
- Movement disorder

EXPECTED OUTCOME

Resident will:

1. Be free of falls/injury.
2. (circled) Minimize risks of falls/injury (personal-environmental).
3. Other________

OUTCOME EVALUATION (Adj. / Due / Ach'd Y / N / DC): 2/6/19

INTERVENTIONS / RESPONSIBILITIES

INTERVENTIONS	MSD	RSG	SW	TR	RF	ADM	OTH	DATE DISC.
• Provide for task segmentation								
• (circled) Provide on-going assessment of risk factors		✓				✓		3/7/19
• Investigate cause of fall(s)								
• (circled) Assess judgement/mental status and provide supervision in accordance with needs		✓	✓			✓		3/7/19
• (circled) Orient frequently		✓	✓			✓		
• Encourage use of hearing aid/glasses								
• (circled) Refer to rehab for OT/PT evaluation		✓				✓		✓
• Provide/continue restorative/maintenance OT/PT program								
• Teach safe ambulation/ transfer techniques								
• Provide assistive devices								
• Instruct and monitor use of assistive devices								
• Teach actions that minimize hypotension when changing position								
• (circled) Provide supervision/assistance in ambulation/transfer		✓				✓		3/7/19
• Implement siderails								
• Order/apply/encourage use of proper foot wear								

#1 FALLS/INJURY
☐ ACTUAL
☒ POTENTIAL

Name: Jean Zram...
Room #: 1013B

1. FALLS/INJURY
☐ ACTUAL
☐ POTENTIAL

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: Date	Date	Achvd Y	Achvd N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	HSG	SW	TR	OT	REH	OTH	DATE REVIEWED
	Related to: (continued) • Problem behavior • Other Secondary to: • Medical diagnosis/problem							• Teach actions that minimize hypotension when changing position								
								• Provide supervision/ assistance in ambulation/transfer								
								• Implement siderails								
								• Order/apply/encourage use of proper foot wear								
								• Obtain vision/hearing evaluation		✓						3/19
								• Consider limitations when involved in activities (specify)								
								• Monitor medications and side effects of drugs. Observe for lethargy	✓	✓						
								• Provide counseling to the resident and/or family regarding safety issues		✓	✓					
								• Provide information so that family aware of risk factors		✓	✓					
								• Teach and/or reinforce the use of ambulatory care								
								• Encourage use of walker/canes								
								• Monitor walkers and equipment for safety								
								• Provide a calm environment and reduce the noise level								
								• Other Keep call bell within reach		✓						

RUTLAND NURSING HOME

COORDINATION OF RESIDENT CONCERNS

RESIDENT NAME: _____ **UNIT:** _____ **RESIDENT DIAGNOSIS:** _____

DATE	PROBLEM #	CONCERN	SIGNATURE	DISCIPLINE

BS 5/2014

Comprehe[illegible]are Plan

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: Init	Date	Addressed Y	Addressed N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE DC
	Definition: Use of any medication that affects behavior, mood or thinking. **Evidenced by:** • Psychotropic drug use **Side effects evidenced by:** • Hypotension • Dizziness/vertigo • Syncope • Accidents • Gait disturbance • Movement disorder • Poor balance • Cognitive/behavioral impairment • Major differences in AM/PM performance • Delirium • Withdrawal • Hallucination/delusions • Deterioration in cognition, communication, ADL, continence, mood and/or behavior • Constipation/fecal impaction • Urinary retention • Dry mouth/dehydration • Other_____ **Related to:** • Agitation • Paranoid behavior • Anxiety state • Depression • Behavior problem	**Resident will:** 1. Maximize functional potential and well-being while minimizing use of medication. 2. Be free of accidents. 3. Maintain current level of functioning. 4. Have reduced drug induced side effects. 5. Eliminate use of medication. 6. Other_____						• Implement behavior management program									
								• Assess behavior pattern									
								• Assess resident response to medication									
								• Evaluate action of medication and interactions with other medications									
								• Observe for any signs of decline in functional or cognitive status									
								• Assess postural vital signs and heart rhythm (BP and pulse when resident is lying down) Weekly_____ Daily_____									
								• Monitor for changes in behavior or mood									
								• Observe for drug-induced side effects									
								• Encourage verbalization of feelings									
								• Document behavior, effectiveness of medication and any side effects weekly									
								• Assess for progressive tendency for falls									

9r PSYCHOTROPIC DRUG USE
- ☐ ACTUAL
- ☐ POTENTIAL

Name:_____
Room #:_____
Medical Record Number:_____
Initial Care Plan Date:_____

RUTLAND NURSING HOME

COORDINATION OF RESIDENT CONCERNS

RESIDENT NAME: _____ **UNIT:** _____ **RESIDENT DIAGNOSIS:** _____

DATE	PROBLEM #	CONCERN	SIGNATURE	DISCIPLINE

BS 5/2014

…LAND NURSING HOME
Comprehensive Care Plan

Page 1 of 2

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME
[handwritten: 3/7/19]	**Definition:** Discomfort/pain all or part of the time. **Evidenced by:** • Verbalization (circled) • Protective positioning (circled) • Non-verbal behaviors (circled) • Crying/moaning (circled) • Acute pain symptoms — altered vital signs — nausea — vomiting — fear • Other ________ **Related to:** • Physical condition (circled) • Psychological condition • Pressure ulcer (specify stage): ________ • Abrasions/bruises • Burns 2nd/3rd • Surgical wound • Open lesions • Malignancy • Inappropriate physical activity • Inappropriate positioning • Chest pain • Other ________ **Secondary to:** • Medical diagnosis/problem (circled) [handwritten: CVA.]	**Resident will:** 1. Verbalize/demonstrate through behavior ~~that pain is tolerable~~. (circled) 2. Continue to participate in ADLs/Activities. 3. Utilize pain control measure as per OT/PT/Nursing (specify): ________ 4. Self--medicate. 5. Other ________

OUTCOME EVALUATION: Ac	Dat	A.S's Y	A.S's N	DT	INTERVENTIONS	MED	NSG	SW	TH	OT	REN	UTH	DATE IMP.	DAT DC
[handwritten: 1]					• Observe facial expression for pain (circled)	✓	✓	✓	✓	✓	✓		[handwritten: 3/7/19]	
					• Provide medical management of underlying cause of pain (circled)	✓	✓						(arrow down)	
					• Refer to rehabilitation for evaluation of pain (circled)		✓				✓			
					• Administer medications as ordered by MD (circled)		✓							
					• Evaluate effectiveness of pain medication (circled)	✓	✓							
					• Position for comfort (circled)		✓				✓			
					• Listen to concerns and encourage verbalization									
					• Engage resident in activities/recreation that do not exacerbate pain									
					• Encourage participation in recreation/rehabilitation programs within limits of resident's tolerance									
					• Provide/continue rehabilitation program for pain control									

[handwritten: #4] PAIN
☐ ~~ACTUAL~~
☑ POTENTIAL

Name: ________
Room #:

RUTLAND NURSING HOME

COORDINATION OF RESIDENT CONCERNS

RESIDENT NAME: _____ **UNIT:** _____ **RESIDENT DIAGNOSIS:** _____

DATE	PROBLEM #	CONCERN	SIGNATURE	DISCIPLINE

BS 5/2014

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No	Date	Ad'd Y	Ad'd N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE DC
3/7/19	**Definition:** Impaired ability to control evacuation of urine and/or stool. **Evidenced by:** • Incontinent of bowel • Incontinent of urine **Related to:** • Coma • Cognitive impairment • Sensory impairment • Mobility impairment • Impaired sphincter control • Infection • Drug therapy • Other_____ **Secondary to:** • Medical diagnosis/problem • CVA • Trauma	**Resident will:** 1. Establish a regular pattern of bowel function. 2. Achieve bladder continence. 3. Achieve bowel continence. 4. Demonstrate fewer episodes of incontinence. 5. Accept and use incontinent devices. 6. Participate in recreational programs on/off unit. 7. Maintain skin integrity. 8. Be clean and dry. 9. Follow a regular toileting routine. 10. Leave room for recreation/meals, etc. 11. Verbalize feelings/concerns. 12. Maintain dignity and self esteem. 13. Other_____	4/6/19 8/19					• Assess and evaluate for underlying causes of incontinence • Provide medical management of underlying medical condition • Obtain Urology/GI consult as indicated • Assess skin condition regularly • Plan and implement a bowel and/or bladder rehabilitation program specific to resident's needs • Apply incontinence pads/devices • Plan and implement toileting schedule • Plan and implement a diuretic/fluid intake schedule that supports continence • Toilet resident immediately on request • Plan and implement toileting routine that supports resident's attendance at activities • Engage in activities near toilet facilities		✓						3/7/19	
										✓						3/7/19	

9. BOWEL/BLADDER INCONTINENCE
☑ ACTUAL
☐ POTENTIAL

Name: Bruce Rice, J
Room #:
Medical Record Number:
Initial Care Plan Date: 3/7/19

RUTLAND NURSING HOME

COORDINATION OF RESIDENT CONCERNS

RESIDENT NAME: _____ **UNIT:** _____ **RESIDENT DIAGNOSIS:** _____

DATE	PROBLEM #	CONCERN	SIGNATURE	DISCIPLINE

BS 5/2014

RUTLAN[illegible]RSING HOME
Compre[illegible]ve Care Plan

DATE IMPLE-MENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No.	Date	Addl Y	Addl N	Dc	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DA D
3/7/19	**Definition:** At risk for, or has impairment of oral condition (soft tissue and/or teeth). **Evidenced by:** **Soft Tissue:** • Chewing problem • Swallowing problem • Mouth pain • Mouth debris • Inflamed gums, gingiva, oral abscesses, swollen or bleeding gums or ulcers, rashes • Cracked/dry lips • Swollen tongue • Other_____ _____ _____ **Teeth:** • Has dentures and/or removable bridge • Broken/loose/carious teeth • Some/all natural teeth lost; does not have or did not wear dentures/partial plates • Pain • Other_____ _____ _____ **Related to:** • Chemotherapy • Periodontal disease • Poor circulation • Impaired cognition • Resists mouth care • Medications • Dehydration • Other_____ _____ _____	**Resident will:** 1. Demonstrate an oral cavity that is clean/healing/healed. 2. Be free of or experience tolerable oral/dental-pain/discomfort. 3. Maintain ideal body weight. 4. Demonstrate mouth care as per learning plan. 5. Be free of infection. 6. Other_____ _____ _____	1	4/19				• Daily and PRN cleaning of teeth/dentures		✓						3/7/19	
			2	4/19				• Assess chewing/swallowing ability		✓						4/19	
			5	1				• Assess risk factors on an ongoing basis		✓							
								• Monitor weight regularly as ordered		✓			✓				
								• Monitor food intake O/T F.									
								• Provide dental services regarding assessment/ treatment/follow-up of oral/dental condition	✓	✓							
								• Implement diet as ordered by MD TF.	✓	✓			✓				
								• Provide mouth care every 2 hours								✓	
								• Provide special mouth care as ordered by MD									

17. IMPAIRED ORAL/DENTAL CONDITION
☑ ACTUAL
☐ POTENTIAL

Name: [illegible]
Room #:
Medical Record Number:

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No	Date	Addressed Y	Addressed N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	RSG	SW	TR	OT	REN	OTH	DATE IMP.	DATE DC
	Definition: Presently has an infection or is at risk for an infection. **Evidenced by:** • Urinary incontinence • Fever • Tissue injury • Low hemoglobin • Suppressed immunity • Leukopenia • Elevated white blood cell count • Other_____ _____ _____ **Related to:** • Indwelling urinary catheter • External urinary catheter • Intermittent urinary catheter • Stasis ulcer • Pressure ulcer • Abrasions/bruises • Burns • Surgical wound • Cuts other than surgery • Open lesions • Respiratory infection • Tracheostomy • Suctioning • Feeding tube • Other_____ _____ _____	**Resident will:** 1. Be free of infection 2. Have no signs or symptoms of infection 3. Other_____ _____ _____ _____						• Provide medical management of underlying medical condition									
								• Provide ongoing assessment of infectious process									
								• Implement/maintain isolation as ordered by MD Type:_____									
								• Provide wound care as ordered by MD									
								• Provide diet as ordered by MD									
								• Administer medications as ordered by MD - antibiotics - vitamin C - other									
								• Monitor vital signs frequently									
								• Monitor effect of treatment with follow-up diagnostic testing									
								• Encourage p.o. fluid/caloric intake									
								• Monitor weight/fluid balance and/or intake as ordered									

18. INFECTION
☐ ACTUAL
☐ POTENTIAL

Name:_____
Room #:_____
Medical Record Number:_____
Initial Care Plan Date:_____

RUTLAND NURSING HOME
Comprehensive Care Plan

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION: No.	Date	Addressed Y	Addressed N	D/C	INTERVENTIONS	RESPONSIBILITIES: MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE D/C
3/7/19	**Definition:** Impaired, reduced or distorted perception of visual stimuli. **Evidenced by:** • Halos/ring around lights • Flashes of light/curtain • Side vision problems • Use of visual appliances • Decreased peripheral vision • Tunnel vision • Difficulty moving about • Changes/deterioration in sensation • Behavioral/emotional response(s) • Falls • Inappropriate response - neglect of self • Turning head to see better • Other_____ **Related to:** • Vision impairment/ blindness impaired central/peripheral nervous system • Other_____	**Resident will:** 1. Recognize vision impairment and compensate within limits of ability. 2. Demonstrate adaption to decrease in vision. 3. Become independent in moving about facility. 4. Be injury free. 5. Verbalize/demonstrate an increase in emotional/ psychological comfort regarding perceptual limitations. 6. Use glasses as recommended by ophthalmologist or optometrist. 7. Other_____						• Provide ongoing assessment of vision impairment	✓	✓						3/7/19	
								• Provide vision exams as necessary	✓	✓						3/7/19	
								• Encourage to wear glasses	✓	✓	✓	✓	✓	✓		3/19	
			4	4/19				• Refer to vision services regarding assessment/ treatment/follow-up	✓	✓							
								• Assist/supervise ADLs		✓							
								• Orient frequently to environment		✓	✓	✓					
								• Monitor environment to support safety		✓	✓	✓	✓	✓		3/7/19	
								• Provide emotional support and listen to verbalization of concerns									
								• Engage in recreational activities adapted to limitations									
								• Involve family in implementing plan									
								• Provide mobility instruction - room, halls, building, outdoors, etc.									
								• Provide verbal announcements - Activity Programs / Meal Content / Weather, etc.									
								• Escort/assist to and from Activity Programs, Physician Consultations, Podiatrist, etc.		✓	✓	✓	✓			3/7/19	
								• Escort/assist to and from Dining Room(s), Day Room, etc.		✓	✓	✓	✓			3/19	
								• Instruct/assist in use of hand rails in facility									

32. SENSORY - PERCEPTUAL ALTERATION - VISUAL
- ☑ ACTUAL
- ☐ POTENTIAL

Name: Francisco, J
Room #: 1013B
Medical Record Number:

ATE MP.	RESIDENT PROBLEM/NEED/ STRENGTH	EXPECTED OUTCOME	OUTCOME EVALUATION No.	Date	Achieved Y	Achieved N	D/C
3/19	☑ Resident / family expresses desire / need for spiritual support. ☐ Resident experiencing difficulty coping with changes in: ☐ Living arrangements (adjustment to institutionalization / de-institutionalized) or lifestyle ☐ Mental Status ☐ Physical capacity ☐ Customary daily routine(s) ☐ Less ☐ Other (specify): _____ _____ _____ ☐ Resident declines spiritual support activities. ☐ No information re: spirituality available at this time.	1. Resident will participate in religious activities 1 x/ per week for next 90 days. 2. Resident will participate in support group meetings ____ x/ per week for next ____ days. 3. Resident will demonstrate fewer episodes of problematic behavior (specify):_____ _____ for next ____ days. 4. Resident will report decrease in frequency of expressions of grief for next ____ days. 5. Resident will engage in 23 number of activities per week for next 90 days. 6. Other: _____ _____ _____	1 5	6/19 /19			

INTERVENTIONS	Responsible Discipline: M	N	SW	TR	DT	R	OTHER	DATE IMP.	DATE D/C
Pastoral counseling									
Religious services				✓				3/19	
Individual counseling									
Couples counseling									
Group counseling									
Family counseling									
Religious readings									
Stress Management Group									
Education: stress management									
Education: relaxation techniques / exercises									
Staff / volunteer visits			✓	✓	✓				
Education: meditation									
Decorate room/space									
Recognize achievements									
Community activities									
Verbal / Music Stimulation									

50. SPIRITUAL NEEDS

DO NOT REMOVE

Name: Gariepy, Jean
Room #: 101BB
Medical Record #:
Initial CCP Date:

FRANCISQUE ,JEAN
FRANCI E ,GLADYS
917-325-1931
I CATHOLIC TW 1013B
BTCM/WUBSHET, B.

ACCNT#: 1643155

12. FEEDING TUBE

☐ ACTUAL
☐ POTENTIAL

RUTLAND NURSING HOME
COMPREHENSIVE CARE PLAN

Page 1 of 1

DATE	RESIDENT CONCERN	EXPECTED OUTCOME THE RESIDENT WILL	NO.	TARGET DATE	INTERVENTIONS	RESP. DISC.	DA IMPL.	DISC.	ENTER DATE, SIGNATURE, TITLE, AND OUTCOME
3/9/2019	Definition: A state in which resident receives some or all of fluids and/or nutrients via a tube in the gastrointestinal tract. Evidenced by: • Feeding tube present Related to: • Coma • Cognitive impairment • Impaired swallowing • Esophageal pathology • Severe anorexia • Other (specify) _____ Secondary to: • Medical diagnosis/problem Stroke Lt heel DTI HTN DM • CVA • Trauma	Resident will: 1. Tolerate tube feeding as ordered. 2. Be free of signs/ symptoms of complications of tube feeding. 3. Maintain weight of use 4. Gain/lose weight of _____ pounds by next assessment. 5. Improve and/or maintain skin integrity. 6. Be successfully weaned from tube feeding. 7. Be adequately hydrated as evidenced by normal lab values for the resident and signs and symptoms of adequate hydration. 8. Receive adequate nutrition via tube feeding. 9. Other (specify) _____	1 2 3 5 6 7 8	6/19	• Monitor weight regularly monthly; weekly; pm • Monitor/report to MD signs/symptoms of complications of tube feeding • Administer tube feeding/fluid intake as ordered by MD • Provide nasal / oral stoma care as per protocol. • Elevate head of bed 30°-45° during feeding • Refer to speech therapist • Plan and implement a program for weaning resident from the tube feeding • Provide positive reinforcement and emotional support • Coordinate dysphagia program • Monitor p.o. tolerance/intake • Adjust or change tube feeding formula prn • Other (specify) _____	P N MD SLP	3/9/2019 3/9/2019		3/9/2019 Admit SBAR on YTF / Lt heel DTI

RUTLAND NURSING HOME
Comprehensive Care Plan

DATE IMPLEMENTED: 3/19

RESIDENT PROBLEM

Definition: Insufficient, excessive ineffective, and/or inappropriate social interaction and/or decreased interest, engagement in or response during recreational pursuits.

Evidenced by:

- Preferences for more or different activity choices
- Not involved in activities
- Involved in activities more than 2/3 of time
- Involved in activities less than 1/3 of time
- Verbalizes no interest or intolerance of social interaction
- Withdrawn - dull effect
- Anxiety in public places
- Difficulty in transferring interests
- Resistance to leaving unit
- Discomfort in group setting
- Limited attention span
- Reluctance to respond to stimuli
- Absence of activity preference
- Other________

Related to:

- Medical orders for isolation
- Bedfast all or most of time
- Verbally abusive
- Avoids interaction with others
- Easily fatigued
- Never awake for a substantial period of time
- Preference for own room

EXPECTED OUTCOME

Resident will:

1. Indicate interest in opportunities for social interaction.
2. Verbalize problems with interactions with peers/staff.
3. Participate increasingly in social/recreational activities (specify): Socials, parties, Chtoir
4. Identify and engage in activities of interest.
5. Establish relationship(s) with staff/peers.
6. Successfully modify interests in response to physical/emotional limitations.
7. Respond to stimuli provided during activities.
8. Engage in independent activities of choice.
9. Maintain attention span during groups.
10. Derive feelings or satisfaction/gratification during involvement in activities or relationships.
11. Other: Resident will respond via facial expression to tactile stimulation (rubbing) during 1:1 visits 2x per week over next 90 days.
12. Resident will answer 1-2 basic questions daily 1:1 visits 1x per week over next 90 days.

OUTCOME EVALUATION

No	Date	Ach'd Y	Ach'd N	DC
3	6/19			
7	6/19			
11	6/19			
12	6/19			

INTERVENTIONS / RESPONSIBILITIES

INTERVENTIONS	MED	NSG	SW	TR	OT	REH	OTH	DATE IMP.	DATE DC
• Assist resident in identification of likes and dislikes related to recreational activities									
• Encourage participation in recreation plan									
• Engage in individual activities (specify): tactile stimul., Poetry Reading, Reading Stories				✓				3/19	
• Engage in group programs (specify): Parties, Chtoir				✓					
• Encourage resident to ventilate feelings									
• Assist residents in establishing compatible relationship(s) with others									
• Support resident's goals for involvement in recreational pursuits									
• Encourage resident to leave room									
• Encourage resident to engage in off unit activities									
• Evaluate potential for participation in community-based activities									

37. IMPAIRED SOCIAL INTERACTION, AND/OR SOCIAL ISOLATION
☐ ACTUAL
☐ POTENTIAL

DO NOT REMOVE

Name: Francisque, Jean
Room #: 1013B
Medical Record Number:
Initial Care Plan Date:

37. IMPAIRED SOCIAL INTERACTION, AND/OR SOCIAL ISOLATION

☐ ACTUAL
☐ POTENTIAL

DATE IMPLEMENTED:

RESIDENT PROBLEM

Related to: (continued)

- Preference for activities outside nursing home
- Does not feel comfortable in any activity setting
- Ostomy
- Joint pain
- Sad or anxious mood
- Chemotherapy
- Quadriplegia
- Lack of interest in activities offered
- Incontinence of urine
- Incontinence of bowels
- Institutionalization / relocation
- Grief over lost status/roles
- Unsettled relationships
- Non-English speaking
- Coma
- Unclear or slurred garbled speech
- Impaired vision
- Self image problem
- Psychiatric illness
- Impaired cognition
- Lifestyle issues
- Acute/terminal illness
- Time consuming treatments or rehab care
- Limited time awake
- Communication problem
- Impaired mobility
- Decline in functional ability
- Other________

EXPECTED OUTCOME:

OUTCOME EVALUATION (No. | Date | Ach'd Y | Ach'd N | D/C): blank

RESPONSIBILITIES

INTERVENTIONS	MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE D/C
• Encourage participation in prescribed activities		✓	✓	✓	✓			3/19	
• Encourage decision making/ independent choices regarding recreational involvement									
• Provide praise for achievements/support self-esteem		✓	✓	✓	✓				
• Adapt/modify activity for successful participation									
• Teach skills as necessary for successful involvement									
• Allow resident time to respond				✓					
• Provide individual/group/ family therapy/counseling									
• Stimulate with radio/television during part of day				✓					
• Encourage family participation in programs with resident									
• Assign staff consistently									
• Provide bed-side activities				✓					
• Schedule one-to-one activities				✓					
• Arrange chaplaincy services									
• Provide one-to-one music sensory stimulation									
• Provide tactile stimulation				✓					
• Other: Rec. Staff will provide [illegible]				✓					

RUTLAND N[illegible]NG HOME
Comprehen[illegible] Care Plan

DATE IMPLEMENTED: 3/7/19

RESIDENT PROBLEM

Definition: Inability to provide for all of one's own ADL needs and is totally dependent on staff for assistance.

Evidenced by:

- Total assistance needed in:
  - Bed mobility
  - Transfer
  - Locomotion
  - Dressing
  - Toilet use
  - Personal hygiene
  - Bathing

Related to:

- Sequencing problems
- Incomplete performance
- Anxiety
- Weakness (circled)
- Poor balance
- Poor coordination (circled)
- Contractures, specify site(s): ______
- Sensory impairment (circled)
- Pain
- Impaired decision making
- No memory recall ability
- Loss of voluntary movement
- Unstable, fluctuating, precarious or deteriorating condition/disease (circled)
- Coma
- Hemiplegia
- Quadriplegia
- Other ______

EXPECTED OUTCOME

Resident will:

1. Be clean, dry and well groomed daily. (circled)
2. Maintain skin integrity.
3. Maintain integrity of oral/dental soft/hard tissue. (circled)
4. Be free of infection.
5. Maintain present range of motion in all joints - specify: ______ (circled)
6. Other ______

OUTCOME EVALUATION

No.	Date	ADL'S Y	ADL'S N	D/C
1	6/19			
3	1/19			
5	1 ✓			

INTERVENTIONS / RESPONSIBILITIES

INTERVENTIONS	MED	NSG	SW	TR	DT	REH	OTH	DATE IMP.	DATE DC
• Encourage resident to make choices associated with ADL's where possible									
• Pace care to avoid tiring									
• Provide encouragement/ identify progress/offer praise (circled)									
• Provide total assistance with bed mobility (circled)		✓						3/7/19	
• Turn and position regularly (circled)		✓							
• Utilize pressure relief devices as per nursing orders (circled)									
• Assess skin regularly (circled)		✓							
• Provide total assistance during transfer (circled) 1 person ___ 2 person ✓		✓				✓			
• Use mechanical lift to transfer (circled)									
• Provide total assistance with locomotion (circled)		✓				✓			

SELF CARE DEFICIT - TOTAL
☒ ACTUAL
☐ POTENTIAL

Name: Franqueque, J [illegible]
Room #: 1013B
Medical Record Number: [illegible]

DATE IMPLEMENTED	RESIDENT PROBLEM	EXPECTED OUTCOME	OUTCOME EVALUATION					INTERVENTIONS	RESPONSIBILITIES							DATE REVIEWED
			No	Date	Ach'd Y	Ach'd N	D/C		MED	NSG	SW	TR	OT	SPEE	OTH	
	Secondary to: • Trauma • CVA • Dementia • Multiple Sclerosis • Parkinson's Disease • Medical diagnosis/problem. _____ _____							• Provide wheelchair/geri-chair/ recliner or other: _____ _____								
								• Provide total assistance with dressing/grooming		✓						3/1/19
								• Remove facial hair daily/regularly.		✓						
								• Apply deodorant after physical hygiene								
								• Provide proper footwear								
								• Clip nails regularly in accordance with preferences/safety needs								
								• Provide total assistance with toileting								
								• Provide perineal care daily and whenever necessary								
								• Provide total assistance with bathing/hygiene								
								• Provide 2 baths/showers weekly and whenever necessary								
								• Brush teeth and provide mouth care morning, bedtime and whenever necessary								
								• Wash hair weekly								
								• Provide passive range of motion to: All 4 Exts		✓						3/1/19
								• Provide active range of motion to: _____ _____								
								• Provide skills training/practice in: _____ _____								
								• Other:_____ _____ _____								

TW- 1013B

Home
Manage
Incoming Referrals
Search
Reports
Info
Configure
Help
Logoff

Site Name	Assigned	Last Activity Date	Respond by Date	Response Status	Response Reason Date/Time Provider Can Take Patient	Comments
Rutland Nursing Home/Kingsbrook Jewish Medical Center	Unassigned	3/5/2019 5:08 PM (ET)	2/27/2019 10:47 AM (ET)	Waiting for your response		please forward signed screen and pt's social security number

Response History

Contact Name	Response Received	Response	Reason	Comment
Nadine Nicholas	3/5/2019 5:08 PM (ET)	-	-	SAR @ Rutland.I. Auth ref # 57990740-1000 at level 2 x 5days starting today. F/up w/ CM Alyssa ph: 860 687 5608 Fx 959 262 1043
Nadine Nicholas	2/28/2019 3:32 PM (ET)	-	-	We should have auth shortly, let's prepare for this evening discharge
Karen Telesford	2/28/2019 1:48 PM (ET)	Yes, willing to accept patient	-	please forward signed screen and pt's social security number
Nadine Nicholas	2/28/2019 1:21 PM (ET)	-	-	Are u accepting
Nadine Nicholas	2/27/2019 11:37 AM (ET)	-	-	Any decision?
Karen Telesford	2/27/2019 2:06 AM (ET)	Interested, but need more information	-	being reviewed

Referral Information - Referral # 49989654 - MRN: 000002840513 - JEAN FRANCISQUE

Sending Organization:	NYCHHC 2014 - Kings County Hospital		
Referral ID:	49989654	**Referral Type:**	SNF: Short-term
Date First Sent:	2/28/2019 5:47 PM (ET)	**Most Recent Revision:**	3/5/2019 5:08 PM (ET)
Respond by Date:	2/27/2019 10:47 AM (ET)		
Primary Referral Category:		**Primary Referral Reason:**	
Sender's last activity:	3/5/2019 5:08 PM (ET)	**Your last activity:**	2/28/2019 1:48 PM (ET)

Contact Information

Nadine Nicholas
Phone: (718) 245-2888

Forms - Referral # 49989654 - MRN: 000002840513 - JEAN FRANCISQUE

Form	Size	Action	
PRI	~0K	View File	[fax to me]

File Attachments - Referral # 49989654 - MRN: 000002840513 - JEAN FRANCISQUE

File	Uploaded On	Size	Description	Action	
FaxAttachment.pdf	2/26/2019 11:55 AM (ET)	~149K	H&P	View File	[fax to me]
FaxAttachment.pdf	2/26/2019 12:16 PM (ET)	~574K	PRI ATTACHMENTS	View File	[fax to me]

Patient Information - Referral # 49989654 - MRN: 000002840513 - JEAN FRANCISQUE

Name:	JEAN FRANCISQUE	**MRN:**	000002840513
Date of Birth:	(71 years)	**Gender:**	Male
Address:	25 TENNIS CT 2E 0 BROOKLYN, NY 11226	**Home:** **Work:** **Alt:**	
Marital Status:	Single Married	**SSN:**	
Race:	Black	**Race 2:**	
Religion:	Catholic		

Pt

917-325-1931

Religion:	UNKNOWN		

Admission Information - Referral # 49989654 - MRN: 000002840513 - JEAN FRANCISQUE

Account #:	000039022694	**Patient Type:**	Inpatient
Admission Date:	2/7/2019 10:14 PM (ET)	**Projected Discharge Date:**	2/28/2019 11:00 AM (ET)
Patient Class:	Ward	**Admit Source:**	EMERGENCY OUTPATIENT
Service Type:	NEUROLOGY	**Location:**	D2S / D2S0-7B
Facility:	NYCHHC Kings County Hospital Center	**Level of Care:**	

Primary Diagnosis:	Stroke with hemorrhagic conversion .PEG placed on 2/22

Admitting Physician:	HELEN A VALSAMIS	
Attending Physician:	HELEN A VALSAMIS	

Financial Information - Referral # 49989654 - MRN: 000002840513 - JEAN FRANCISQUE

Financial Class:	Medicare Managed Care

Payment Sources

Primary		
	Financial Class:	Medicare Managed Care
	Plan Number:	W247255639A
	Plan Description:	AETNA MCARE ADVANTAGE
	Plan Provider Contact:	(800) 624-4478
	Certification Status:	Y

Guarantor:	JEAN FRANCISQUE 25 TENNIS CT 2E 0 BROOKLYN, NY 11226 Relationship: Self	

Assessment/Needs - General Information - Referral # 49989654 - MRN: 000002840513 - JEAN FRANCISQUE

Primary Language:	Creole

New York State Department of Health

RUG II Group (print name): PE9

RHCF Level of Care: ☐ HRF ☑ SNF

HOSPITAL AND COMMUNITY PATIENT REVIEW INSTRUMENT (H/C-PRI)

Use with separate Hospital and Community PRI Instructions

I. ADMINISTRATIVE DATA

1 OPERATING CERTIFICATE NUMBER (1-8): 7 0 0 2 0 2 1 H

2 SOCIAL SECURITY NUMBER (9-17):

3 OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW
NYCHHC 2014 - Kings County Hospital

4A PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY) JEAN FRANCISQUE

4B COUNTY OF RESIDENCE KINGS

5 DATE OF PRI COMPLETION (18-25): 0 2 (MO.) 2 6 (DAY) 2 0 1 9 (YEAR)

6 MEDICAL RECORD NUMBER/CASE NUMBER (26-34): 000002840513

7 HOSPITAL ROOM NUMBER (35-39): D 2 S 0 -

8 NAME OF HOSPITAL UNIT/DIVISION/BUILDING
D2S

9 DATE OF BIRTH (40-47): MO. DAY YEAR

10 SEX (48): 1 = Male, 2 = Female → 1

11A DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT (49-56): 0 2 (MO.) 0 7 (DAY) 2 0 1 9 (YEAR)

11B DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE) (57-64): 0 2 (MO.) 2 2 (DAY) 2 0 1 9 (YEAR)

12 MEDICAID NUMBER (65-75):

13 MEDICARE NUMBER (76-85): W 2 4 7 2 5 5 6 3 9

14 PRIMARY PAYOR (86): 1 = Medicaid, 2 = Medicare, 3 = Other → 2

15 REASON FOR PRI COMPLETION (87): 1. RHCF Application from Hospital, 2. RHCF Application from Community, 3. Other (Specify: _____) → 1

II. MEDICAL EVENTS

16 **DECUBITUS LEVEL:** ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS. (88): 0

17 **MEDICAL CONDITIONS:** DURING THE PAST WEEK. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS. 1 = Yes 2 = No

A. Comatose	(89)	2
B. Dehydration	(90)	2
C. Internal Bleeding	(91)	2
D. Stasis Ulcer	(92)	2
E. Terminally Ill	(93)	2
F. Contractures	(94)	2
G. Diabetes Mellitus	(95)	2
H. Urinary Tract Infection	(96)	2
I. HIV Infection Symptomatic	(97)	2
J. Accident	(98)	2
K. Ventilator Dependent	(99)	2

18 **MEDICAL TREATMENTS:** READ THE INSTRUCTIONS FOR QUALIFIERS 1 = Yes 2 = No

A. Tracheostomy Care/Suctioning (Daily - Exclude self care)	(100)	2
B. Suctioning - General (Daily)	(101)	2
C. Oxygen (Daily)	(102)	2
D. Respiratory Care (Daily)	(103)	2
E. Nasal Gastric Feeding	(104)	2
F. Parenteral Feeding	(105)	2
G. Wound Care	(106)	2
H. Chemotherapy	(107)	2
I. Transfusion	(108)	2
J. Dialysis	(109)	2
K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS)	(110)	2
L. Catheter (Indwelling or External)	(111)	2
M. Physical Restraints (Daytime Only)	(112)	2

III. ACTIVITIES OF DAILY LIVING (ADLs)

Measure the capability of the patient to perform each ADL 60% or more of the time it is performed during the past week (7 days). Read the Instructions for the Changed Condition Rule and the definitions of the ADL terms.

19 EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE, PLATE, CUP, TUBE)

19 (115) 5

1 = Feeds self without supervision or physical assistance. May use adaptive equipment.

2 = Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.

3 = Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.

4 = Totally fed by hand, patient does not manually participate.

5 = Tube or parenteral feeding for primary intake of food. (*Not* just for supplemental nourishments.)

20 MOBILITY: HOW THE PATIENT MOVES ABOUT.

20 (114) 5

1 = Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.

2 = Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).

3 = Walks with *constant* one-to-one supervision and/or constant physical assistance.

4 = Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.

5 = Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

21 TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET).

21 (116) 5

1 = Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.

2 = Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.

3 = Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.

4 = Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.

5 = Cannot and is not gotten out of bed.

22 TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN), TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES

22 (116) 4

1 = Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.

2 = Requires *intermittent* supervision for safety or encouragement, or minor physical assistance (for example, clothes adjustment or washing hands).

3 = Continent of bowel and bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, including appliances (i.e., colostomy, ileostomy, urinary catheter).

4 = Incontinent of bowel and/or bladder and is not taken to a bathroom.

5 = Incontinent of bowel and/or bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

V. BEHAVIORS

23 VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC.

23 (117) 1

1 = No known history.

2 = Known history or occurrences, but not during the past week (7 days).

3 = Short-lived or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing.)

4 = Unpredictable, recurring verbal disruption at least once during the past week (7 days) for no foretold reason.

5 = Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).

24 PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY, (FOR EXAMPLE HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR)

24 (118) 1

1 = No known history.

2 = Known history or occurrences, but not during the past week (7 days).

3 = Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.

4 = Unpredictable, recurring aggression at least once during the past week (7 days) for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).

5 = Patient is at level as #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).

VII. PLAN OF CARE SUMMARY

This section is to communicate to providers any additional clinical information which may be needed for their preadmission review of the patient. It does not have to be completed if the information below is already provided by your own form, which is attached to this H/C-PRI.

30 DIAGNOSES AND PROGNOSES: FOR EACH DIAGNOSIS DESCRIBE THE PROGNOSIS AND CARE PLAN IMPLICATIONS.

Primary — Prognosis

1. Stroke with hemorrhagic conversion .
   PEG placed on 2/22

Secondary (Include Sensory Impairments)

PMH: HTN and DM
Wt 156 lbs Ht 5'7"

31 REHABILITATION POTENTIAL [INFORMATION FROM THERAPIST(S)]

A. POTENTIAL DEGREE OF IMPROVEMENT WITH ADLs WITHIN SIX MONTHS (DESCRIBE IN TERMS OF ADL LEVELS ON THE HC-PRI):

Awake . open eyes to verbal commands
REHAB CLINICALS ARE ATTACHED
PLOF:Ambulatory

B. CURRENT THERAPY CARE PLAN: DESCRIBE THE TREATMENTS (INCLUDING WHY) AND ANY SPECIAL EQUIPMENT REQUIRED.

Continue w/ OT and PT for Bed mobility, Gait training w/assistive device, ADL retraining

32 MEDICATIONS

NAME	DOSE	FREQUENCY	ROUTE	DIAGNOSIS REQUIRING EACH MEDICATION
MED list is attached				

33 TREATMENTS: INCLUDE ALL DRESSINGS, IRRIGATIONS, WOUND CARE, OXYGEN.

A. TREATMENTS	DESCRIBE WHY NEEDED	FREQUENCY
BP and glucose monitoring and management		
Fall precautions.		
IPC to b/l LE : DVT prophylaxis		

B. NARRATIVE: DESCRIBE SPECIAL DIET, ALLERGIES, ABNORMAL LAB VALUES, PACEMAKER.

CHO enteral feeding via PEG at 55cc/hr. NKA

34 RACE/ETHNIC GROUP: CIRCLE THE CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP.

1 = White	4 = Black/Hispanic	7 = American Indian or Alaskan Native
2 = White/Hispanic	5 = Asian or Pacific Islander	8 = American Indian or Alaskan Native/Hispanic
3 = Black	6 = Asian or Pacific Islander/Hispanic	9 = Other

35 QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS H/C-PRI ☑ YES ☐ NO

[signature] EREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND

IDENTIFICATION NO. 7 1 3 2 8

NAME: JEAN FRANCISQUE

MEDICATIONS (from page 4, question 32)

	NAME	DOSE	FREQUENCY	ROUTE	DIAGNOSIS REQUIRING EACH MEDICATION
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

TREATMENTS (from page 4, question 33)

	TREATMENTS	DESCRIBE WHY NEEDED	FREQUENCY
1			
2			
3			
4			
5			

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care – Division of Residential Services

SCREEN

A Patient Review Instrument (PRI) or Hospital and Community PRI (H/C PRI) must be completed before beginning the SCREEN form. Refer to the SCREEN Instructions (DOH-695I) when completing the SCREEN form.

IDENTIFICATION

1. Facility Operating Certificate Number: 7002021H
2. Patient/Resident/Person's Social Security Number: 101 - 54 - 1756
3. Name of Person(s) Completing SCREEN: Anthony Parris
4. Patient/Resident/ Person's Name: JEAN FRANCISQUE
5. Date of HC-PRI or PRI Completion: 2/26/19
6a. Date of SCREEN Initiation: 02/28/2019
6b. Date of SCREEN Completion: 02/28/2019

DIRECT REFERRAL FACTOR FOR RESIDENTIAL HEALTH CARE FACILITY (RHCF)

	YES	NO	
7.	☑	☐	This person has a home in the community (owns or rents a home, lives in an Adult Care Facility or with family or friends) and that residence is still available OR appropriate community based living can be arranged OR this person is eligible for an Adult Care Facility.

Guideline: **If item 7 is marked YES, proceed to DIRECT REFERRAL FACTORS FOR COMMUNITY BASED ASSESSMENT (items 8-12). If item 7 is marked NO, explain on a separate sheet of paper and attach to this form; refer to RHCF. Proceed to REFERRAL RECOMMENDATION (item 21).**

DIRECT REFERRAL FACTORS FOR COMMUNITY BASED ASSESSMENT

Answer all items 8-12

	YES	NO	
8.	☐	☑	This person understands information given and opposes placement/continued stay in a Residential Health Care Facility.
9.	☐	☑	This person is aware of the cost of necessary community services and desires to use private resources (e.g., insurance, income, savings) to purchase care at home or in an Adult Care Facility. Evaluator specifically described all necessary community services and described private resources (such as insurance coverage, savings, income or financial aid provided by a spouse, relative or friend) that may be available to pay for such services. Medicare and Medicaid should NOT be included as private financial resources.
10.	☐	☑	This person has an informal support system. Individuals in this system are willing and are physically and mentally capable of caring for this person, and providing for most of his/her specific needs.
11.	☐	☑	All ADL responses = 1 or 2 (see PRI or HC-PRI PART III, 19-22)
12.	☑	☐	This person was independent in ADLs prior to most recent acute episode and shows good rate of return of physical and mental functioning.

Guideline: **If any direct referral factor (items 8-12) is marked YES, refer to a Certified Home Health Agency (CHHA) for a community based assessment. Attach assessment to the SCREEN, then proceed to REFERRAL RECOMMENDATION (item 21). If all referral factors (items 8-12) are marked NO, proceed to HOME AND CAREGIVING ARRANGEMENTS (item 13).**

HOME AND CAREGIVING ARRANGEMENTS

13. a. Estimate the total number of hours per day that the informal support(s) system is willing and able to provide supervision or assistance to this person. a. 0

b. Estimate the total number of hours per day that this person can be alone. b. 0

c. Add a and b (a+b=c) ..... c. 0

YES	NO	
☐	☑	d. Does c. total 12 or more hours?

Guideline: **If item 13d. is marked YES, proceed to item 16. If item 13d. is marked NO, proceed to item 14.**

YES NO

14. ☑ ☐ Can the number of hours that this person is attended by self or informal supports be expected to increase to 12 or more hours per day within six months?

Guideline: **If item 14 is marked YES, proceed to item 16.**
If item 14 is marked NO, proceed to item 15.

15. If the answer to item 14 is NO, enter reason(s) (a, b, and/or c): _____

a. This person's physical and/or mental condition is not expected to improve to a degree that would permit increased self care within six months.
b. Person has no informal supports.
c. Informal supports are unable or unwilling to provide additional assistance, or person does not want care from informal supports.

Guideline: **Proceed to item 16**

YES NO

16. ☑ ☐ Is there a need for restorative services documented by a physician or rehabilitation specialist?

Guideline: **If item 16 is marked YES, proceed to item 17.**
If item 16 is marked NO, proceed to item 19.

YES NO

17. ☐ ☑ Can this person receive restorative services at home, at adult day care, or as an outpatient?

Guideline: **If item 17 is marked YES, proceed to item 19.**
If item 17 is marked NO, proceed to item 18.

18. If the answer to item 17 is NO, enter reason(s) (a, b and/or c): c

a. Restorative services are not available in this person's community.
b. Restorative services are too costly or not covered in this person's community.
c. This person cannot access restorative services in their community.

Guideline: **Proceed to item 19.**

YES NO

19. ☑ ☐ Does this person have any risk factors that could cause undue risk to self or others if placed in the community?

If YES, enter reason(s) (a, b, c and/or d): d

a. This person has a history of unpredictable behaviors and may injure self or others. This condition is not temporary.
b. Comatose (PRI or H-C PRI Part II, 17 A) or all ADL responses = 4 or 5 (PRI or H-C PRI PART III, 19-22).
c. Requires constant monitoring due to health threatening medical conditions.
d. Skilled services are needed at least one time per day and cannot be delegated to nonprofessionals or informal supports.

Guideline: **Proceed to item 20.**

YES NO

20. ☐ ☑ Based on the answer to item 19, can this person be placed safely in the community without causing undue risk to self or others?

Guideline: **Proceed to item 21.**

REFERRAL RECOMMENDATION

21. **Based on the information obtained by the screener during the screen assessment, check the principal referral recommendation and reason. Explain as needed:**

---

a. **RHCF:**

1. ( ) A community based assessment was done by a Certified Home Health Agency (CHHA), and it was determined that this person cannot be cared for in the community. This community assessment represents this person's current status.

2. ( ) This person does not have an available home in the community (does not own or rent a home, is not eligible for an Adult Care Facility, or cannot live with family or friends).

3. ( ) Appropriate community based living cannot be arranged because this person cannot be adequately cared for in the community and/or is a risk to self or others.

4. ( ) Both community based and RHCF care are being investigated. Recommendation is RHCF.

b. **RHCF for Restorative Services:**

1. (✓) This person cannot receive restorative services in their community.

c. **Community:**

1. ( ) A CHHA completed a community based assessment and determined that this person can be cared for in the community.

Guideline: **If RHCF (item 21 a) or RHCF for Restorative Services (item 21 b) is chosen, proceed to item 22.**
If Community (item 21 c) is chosen, proceed to item 36.

DEMENTIA DIAGNOSIS

	YES	NO	
22.	☐	☑	Does this person have a dementia diagnosis (including Alzheimer's disease) documented in the medical record?

Guideline: **Proceed to item 23.**

LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS (MI)

	YES	NO	
23.	☐	☑	Does this person have a serious mental illness?

Guideline: **Proceed to LEVEL I Review for Possible Mental Retardation/Developmental Disability (items 24 -26)**

LEVEL I REVIEW FOR POSSIBLE MENTAL RETARDATION/DEVELOPMENTAL DISABILITY (MR/DD)

Answer ALL items 24-26.

	YES	NO	
24.	☐	☑	Does this person have a diagnosis or documented history of mental retardation and/or a developmental disability, and did the mental retardation or developmental disability manifest itself prior to age 22, and is it likely to continue indefinitely, resulting in substantial functional limitations in three or more areas of major life activity?
25.	☐	☑	Has this person ever been deemed eligible for and/or received MR/DD services, or has this person been referred by an agency that serves persons with MR/DD?

26. ☐ ☑ Does this person present with evidence of cognitive deficits and/or adaptive skill deficits that may indicate the presence of mental retardation or developmental disability?

Guideline: **If item 23 or any of items 24-26 are marked YES, proceed to Categorical Determinations (items 27-30).**
If item 23 and all of items 24-26 are marked NO, proceed to Patient/Resident/Person Disposition (item 36).

CATEGORICAL DETERMINATIONS

Answer ALL items 27-30.

	YES	NO	
27.	☐	☐	Does this person qualify for convalescent care?
28.	☐	☐	Is this person seriously physically ill?
29.	☐	☐	Is this person terminally ill?
30.	☐	☐	Is this person to be admitted for a very brief and finite stay or a provisional emergency admission?

Guideline: **If any of the items 27-30 are marked YES, proceed to DANGER TO SELF OR OTHERS QUALIFIERS (item 31).**
If all are marked NO, proceed to LEVEL II REFERRALS (item 33).

DANGER TO SELF OR OTHERS QUALIFIERS

	YES	NO	
31.	☐	☐	Based on your interview with this person (and/or available informants), and/or a review of this person's medical record, is there any evidence to suggest that this person is, or may have been, a danger to self or others during the past two years?

Guideline: **If item 31 is marked YES, proceed to item 32.**
If item 31 is marked NO, proceed to Patient/Resident/Person Disposition (item 36).

	YES	NO	
32.	☐	☐	Has this person been deemed a danger to self or others based on a current psychiatric evaluation by a licensed mental health professional?

Guideline: **If item 32 is marked YES, proceed to LEVEL II REFERRALS (item 33).**
If item 32 is marked NO, proceed to Patient/Resident/Person Disposition (item 36).

LEVEL II REFERRALS

33. Enter the Level II Referral(s): a, b, or c_____

a. Level II mental illness evaluation by the designated mental health review entity
b. Level II evaluation by the Office of Mental Retardation and Developmental Disabilities
c. Both a and b

Guideline: **Proceed to item 34.**

	YES	NO	
34.	☐	☐	I, as the qualified screener, acknowledge that this Patient/Resident/Person and his/her legal representative* have received verbal and written notification that this Patient/Resident/Person is being referred for a Level II Evaluation.

Guideline: **STOP ! Do not complete items 35 through 38 until you have obtained the Level II recommendations from the designated evaluator(s).**

*Legal representative means an individual whose appointment is made and regularly reviewed by a state court or agency empowered under state law to appoint and review such officers, and having the authority to consent to health/mental health care or treatment of an individual.

LEVEL II RECOMMENDATIONS

YES NO

35. ☐ ☐ Specialized services are recommended based on the Level II Evaluation(s).

Guideline: **Proceed to item 36.**

PATIENT/RESIDENT/PERSON DISPOSITION

36. **Enter one response (a,b,c,d,e,f,g,h,i,j.):** g

a. Home
b. Home with home care services
c. Adult Care Facility
d. Inpatient Psychiatric Care
e. OMR/DD Residential Placement
f. Adult Care Facility with home care services
g. RHCF for restorative services
h. RHCF for other services
i. Person died
j. Other (specify) _____

Guideline: **Proceed to item 37**

PATIENT/RESIDENT/PERSON AND/OR LEGAL REPRESENTATIVE AND/OR HEALTH CARE AGENT ACKNOWLEDGEMENT

37. I have had the opportunity to participate in decisions regarding the arrangements for my continuing care, and I have received verbal and written information regarding the range of services in my community.

Patient not able to sign at this time.

02/28/2019
Date

Patient's family is in agreement w/ D/C plan.
Signature of the patient/resident/person being assessed and/or legal representative and/or health care agent

Fabiola Francisque - Daughter
917 - 535 - 3262

Guideline: **Proceed to item 38.**

QUALIFIED SCREENER

38. I have personally observed/interviewed this person and completed this SCREEN and I certify that I am a trained and qualified SCREENER and the information contained herein is a true abstract of this person's current condition and circumstances.

02/28/2019, Anthony Parris - Social Worker
Print date, name and title of qualified SCREENER

00201500220 9
SCREENER Identification Number (Assigned by NYSDOH)

Signature of qualified SCREENER

NOTIFICATION OF NEED FOR LEVEL II EVALUATION

A Level I SCREEN has been completed for JEAN FRANCISQUE, on _____. This notice serves to inform _____ and his/her legal representative that a Level II Evaluation is required, due to suspected mental illness and/or mental retardation. The Level II Evaluation will be completed by the New York State Office of Mental Health and/or Office of Mental Retardation/Developmental Disability or designee.

_____

Print date, name and title of qualified SCREENER

SCREENER Identification Number
(Assigned by NYSDOH)

_____

Signature of qualified SCREENER